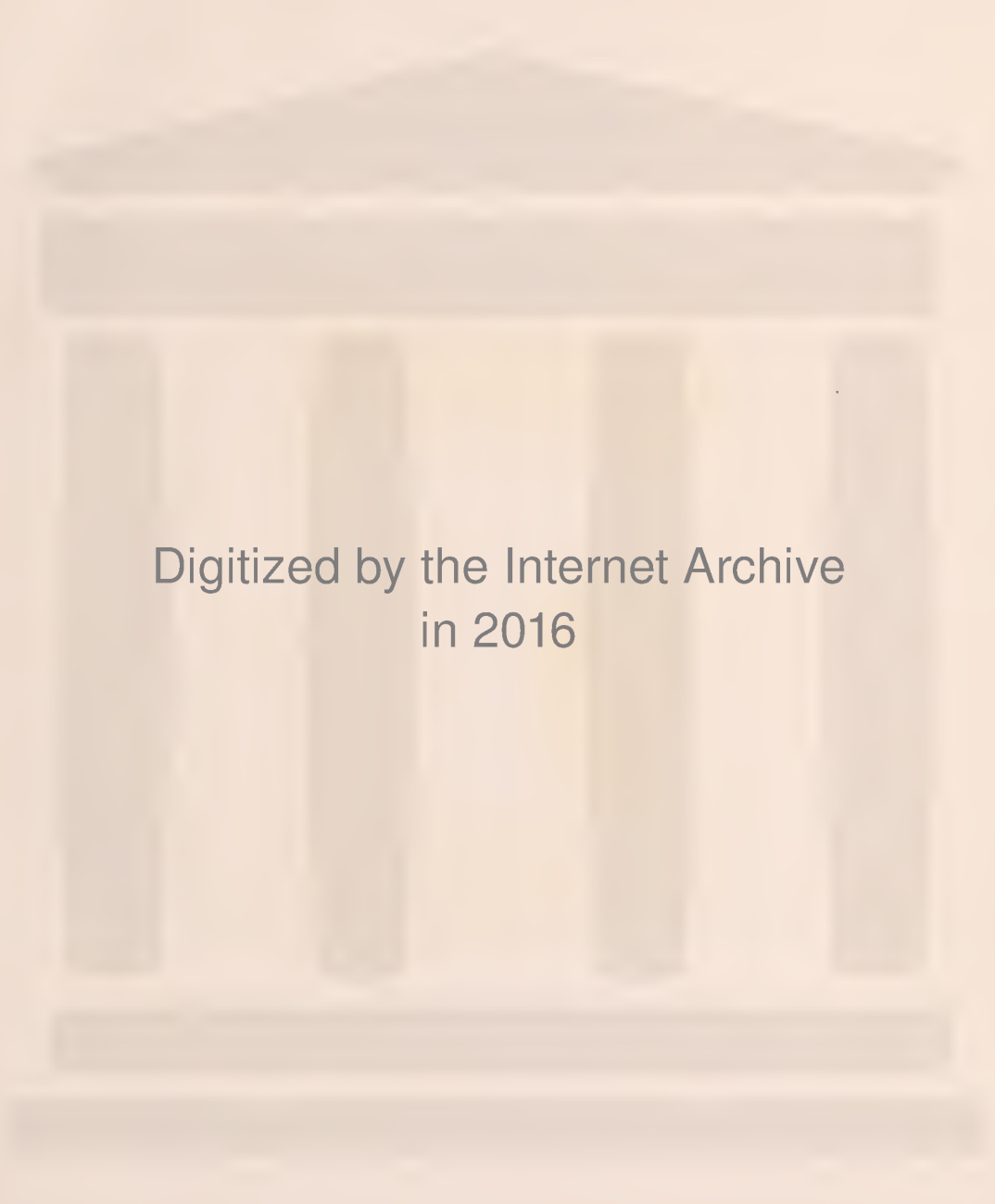


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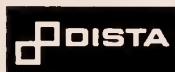
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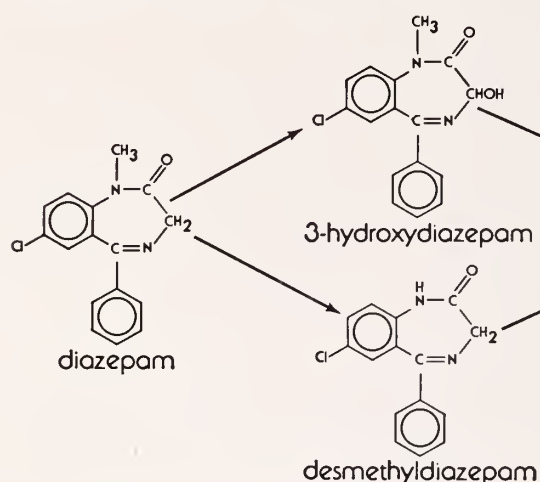
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Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

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Valium® (diazepam)

2-mg, 5-mg, 10-mg scored tablets
**a prudent choice in psychic
tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due

to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated:

Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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HILL CREST HOSPITAL

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AMA Sponsors Conference On Disabled Doctor

Successful programs and various treatment techniques used to help the physician-patient will be the major theme of a second National Conference on the Impaired Physician. The meeting will focus on those physicians suffering from emotional, psychological or pathological conditions that may impair the doctors' judgment and skill.

Sponsored by the AMA and the Medical Association of Georgia, this meeting will be held Feb. 4-6 at the Hyatt Regency Hotel in Atlanta.

Speakers and participants will examine the special problems of the "physician-patient" whose disability is caused by alcoholism, drug dependence or a mental disorder.

According to Richard Palmer, M.D., AMA's president, "organized medicine, by virtue of its professional commitment to the public welfare, must continue to work toward developing effective mechanisms for identifying and treating these physicians."

Two sessions will concentrate on significant case-finding issues and a comparison of several recently

developed medical society and hospital programs.

Featured on the program are workshop sessions on AMA's Model Act and other legislative support mechanisms, the physician and his family, as well as the legal, economic and educational aspects of the problem. To date, more than 25 states have enacted legislation dealing with the "disabled doctor."

Also, specific treatment techniques for the drug addicted, alcoholic or mentally ill physician will be discussed during the workshops.

Highlighting the roster of speakers at this conference are: Richard Palmer, M.D., AMA president; Rogers J. Smith, M.D., conference chairman, Portland, OR; Herbert Raskin, M.D., former chairman of AMA's Committee on Alcoholism and Drug Dependence; Stanley Gitlow, M.D., clinical professor of medicine, Mount Sinai School of Medicine, NY; Charles Whitfield, M.D., director, Alcoholism Education Project, Southern Illinois University; and Douglas Talbott, M.D., program chairman, Disabled Doctors Program, Medical Association of Georgia, and Frank Morgan, M.D., Assistant Health Officer, Mississippi State Board of Health.

Further information on the conference is available through AMA's Department of Mental Health, 535 N. Dearborn St., Chicago, IL 60610.

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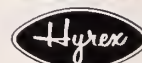
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Volume XVIII

Number 1

January 1977

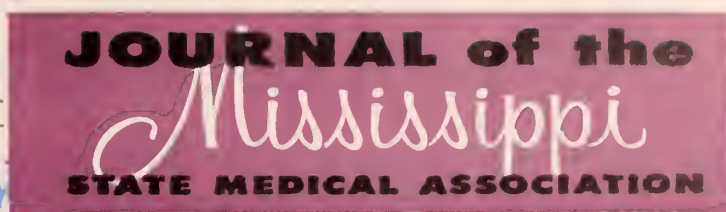


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Holds Regular Fall Meeting

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Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital, the alcohol content is 15%.

See next page for brief summary.

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Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

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These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

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Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

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Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to one-quarter Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

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Full information is available on request.

Family Medicine Review Is Set

The Seventh Family Medicine Review, Session III, is set for Feb. 20-26, 1977, at the University of Kentucky Medical Center in Lexington. Registration fee is \$295.00.

For further information, contact: Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

Miami Beach Hosts ACCP Pulmonary Program

The American College of Chest Physicians will sponsor the postgraduate course, "Management of Acute and Chronic Respiratory Failure" at the Konover Hotel in Miami Beach, FL, Feb. 7-11, 1977. Course co-ordinators are Reuben M. Cherniack, M.D., chairman of the department of medicine, The University of Manitoba, Winnipeg, Canada, and the ACCP Committee on Postgraduate Medical Education.

The initial sessions, of this intensive five-day course, will stress pulmonary function in health and disease and the assessment of the patient with respiratory insufficiency. This will be followed by presentations of the pathology, and pathophysiologic disturbances present in small airway disease, COPD, ARDS, and pulmonary hypertension, which will form the basis for a thorough discussion of management. The faculty will use a variety of educational methods including lectures, with question and answer periods, panel discussions and demonstrations.

Special features of this course will be the cabana sessions, "What's Wrong With My Patient" and "Stump-the-Expert." Both sessions will have case presentations discussed, participants are urged to bring their own case and x-ray films for discussion by the experts. The free exchange of information on the problems related to the recognition and management of acute and chronic respiratory failure in daily practice is encouraged between the student and faculty.

This program has been evaluated for 26 hours credit toward the AMA Physician's Recognition Award under Category 1. Registration fees are: ACCP members, \$160.00; non-member physicians, \$185.00; residents, nurses and allied health professionals, \$125.00. For further information contact Dale E. Braddy, American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068.

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Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

NEWSLETTER

January 1977

Dear Doctor:

The AMA stressed the importance of local determination in its comments on a list of criteria for elective surgery under Medicare and Medicaid prepared by the House Subcommittee on Oversight and Investigations. In a letter to the subcommittee chairman, the AMA said it supported elimination of unnecessary services from Medicare and Medicaid and pointed out that the PSRO program was established to review the necessity and quality of services.

The AMA's letter also noted that the cooperative effort of the AMA, HEW and 38 national specialty societies already has resulted in the publication of Sample Criteria for Short-Stay Hospital Review. "We see no reason to develop additional criteria," the AMA said.

A program on hospital accreditation standards has been developed by the Joint Commission on Hospitals. The program will be held throughout the country and is designed for hospital administrators, trustees, medical staff leadership, nursing administrators and medical records administrators. For information write JCAH, 875 N. Michigan Avenue, Chicago, IL 60611.

More than 300 family practice residencies are now operating in university medical centers and other teaching hospitals throughout the U.S. Sixteen new family practice programs, from New York to Colorado, recently were approved by the Liaison Committee on Graduate Medical Education, bringing the total to 303, according to the American Academy of Family Physicians.

HEW's Medical Services Administration, in a memo to the states, encouraged adoption of the AMA uniform health insurance claim form by all state Medicaid agencies. The agency said the AMA form would meet most Medicaid requirements. The form was developed by the Council on Medical Service in response to a House of Delegates action calling for a means of reducing paperwork and simplifying billing.

Smoking among adults generally has decreased over the past 10 years, a survey of 12,000 persons over 21 has shown. Exceptions are women aged 21 to 24 and 55 and over, and men 65 and over. The National Clearinghouse for Smoking and Health and National Cancer Institute survey showed that overall 39.3 per cent of the men and 28.9 per cent of the women sampled were regular smokers in 1975.

Sincerely,



Nola Gibson
Managing Editor

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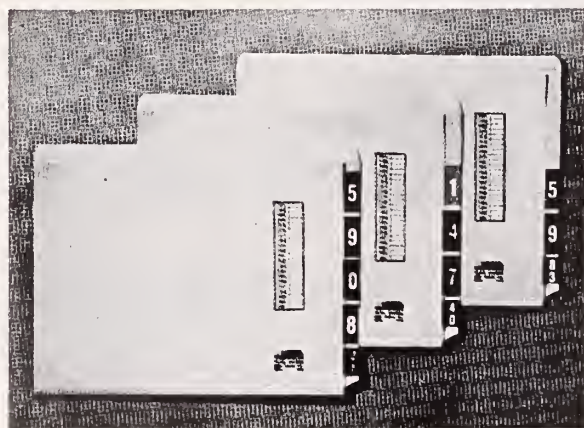
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Modern Endocrinology Is Course Theme

The American College of Physicians will sponsor a three-day postgraduate course on modern endocrinology Feb. 9-11, 1977, in New Orleans, LA. The course will be co-sponsored by the Ochsner Medical Institutions in New Orleans.

The ACP postgraduate courses have been approved by the American Medical Association Advisory Committee on Continuing Medical Education and the New Orleans course may be used to fulfill 22½ hours of Category 1 requirements for the AMA's Physician's Recognition Award.

The New Orleans course, which is formally entitled, "Selected Topics in Endocrinology and Endocrinologic Oncology," is being planned by William Locke, M.D., F.A.C.P., of New Orleans.

For Information and Registration write Registrar, Postgraduate Courses, ACP 4200 Pine Street, Philadelphia, PA 19104.

Cut in Hospital Beds Urged

A National Academy of Sciences panel has called for a 10 per cent decrease in the ratio of hospital beds to population. Claiming that a surplus of short term general care beds is contributing to higher medical costs, the panel said a national health planning goal should be to reduce the present ratio of 4.4 beds per 1,000 persons to 4.0 by 1981.

This would be accomplished by curtailing hospital construction and closing down some existing hospital facilities.

Panel member John D. Thompson, M.S., of Yale University estimates that about 50,000 hospital beds which are now either in use or slated for construction would have to be eliminated. He and the panel stressed the need for waiting periods for elective surgery as a way to increase hospital efficiency and occupancy rates.

The report sponsored by the Academy's Institute of Medicine also recommends shifting from the present system of retrospective cost reimbursement to a prospective rate-setting system. The report states the present third-party system "virtually guarantees the widespread development of excess bed capacity and encourages unnecessary and inappropriate treatment."

AMA Expands Continuing Medical Education Opportunities in 1977.



Now you can choose from 15 regional CME meetings!

Recognizing the importance of continuing medical education to its members, the AMA has greatly expanded its CME programs. During 1977, the AMA will offer 15 regional CME meetings around the country in addition to its scientific programs at both the Annual Convention and Winter Meeting.

The purpose of the regional programs is to make it easier and more convenient for you to continue your medical education by bringing the meetings closer to your hometown and by scheduling them on the weekends to

avoid interference with your practice.

All courses are approved by the AMA Council on Continuing Physician Education for Category 1 credit toward an AMA Physician's Recognition Award. A syllabi written by medical school faculties is provided with every course.

Specific information on course location, fees, academic program, faculty, and hotel reservations will be available approximately 2 months before each course date. Please write to address below at that time stating your selection(s). Print name, address, and office phone number.

1977 Regional Schedule

Tulsa, Oklahoma	January 22-23
Birmingham, Alabama	February 5-6
*Lake Tahoe, Nevada	February 11-13
Denver, Colorado	February 19-20
*Tarpon Springs, Florida	March 4-6
Detroit (Southfield), Michigan	March 26-27
New York (Westchester), New York	April 16-17
Houston, Texas	May 15
Hartford, Connecticut	September 10-11
*Lake of the Ozarks, Missouri	September 16-18
Chicago, Illinois	September 24-25
*Hot Springs (Homestead), Virginia	Sept. 30-Oct. 2
*Huron, Ohio	October 7-9

*Honolulu, Hawaii	Oct. 30-Nov. 4
Hershey, Pennsylvania	November 18-19

AMA's 126th Annual Convention

San Francisco, California	June 18-22
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AMA's Winter Scientific Meeting

Miami Beach, Florida	December 10-13
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AMA Spokesmanship Seminars

Chicago, Illinois	August 13-14
(Marriott O'Hare Hotel)	November 12-13

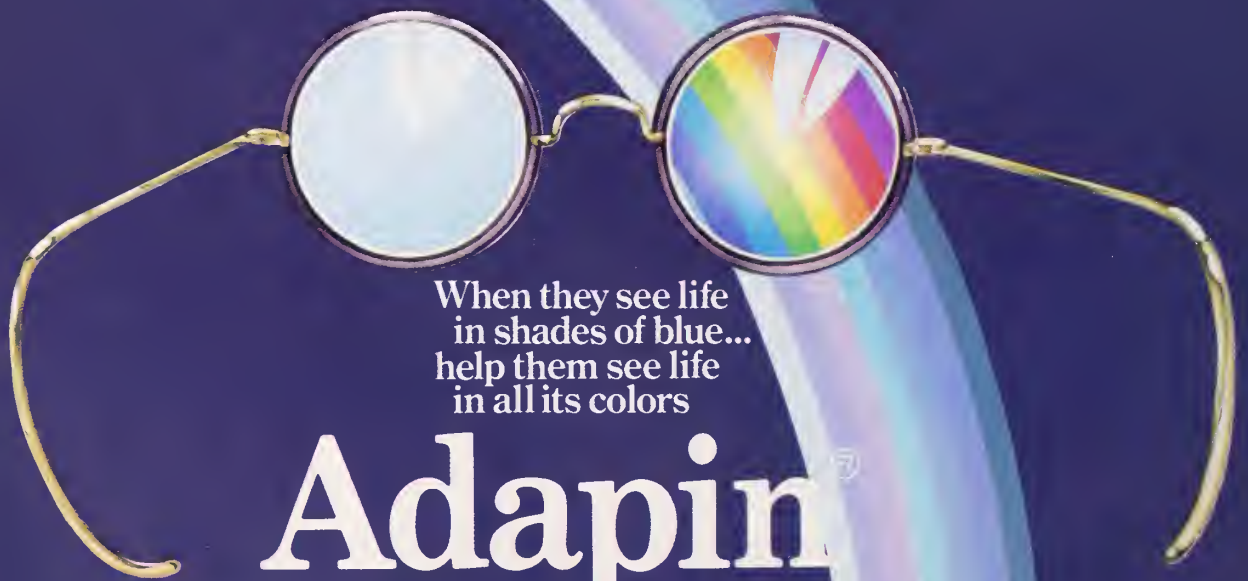
*Courses end at midday for recreation activities

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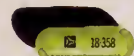
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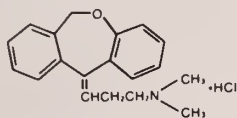
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4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin**.

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—**Adapin** has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin (doxepin hydrochloride)**, gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin**. The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin**; therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression:

10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

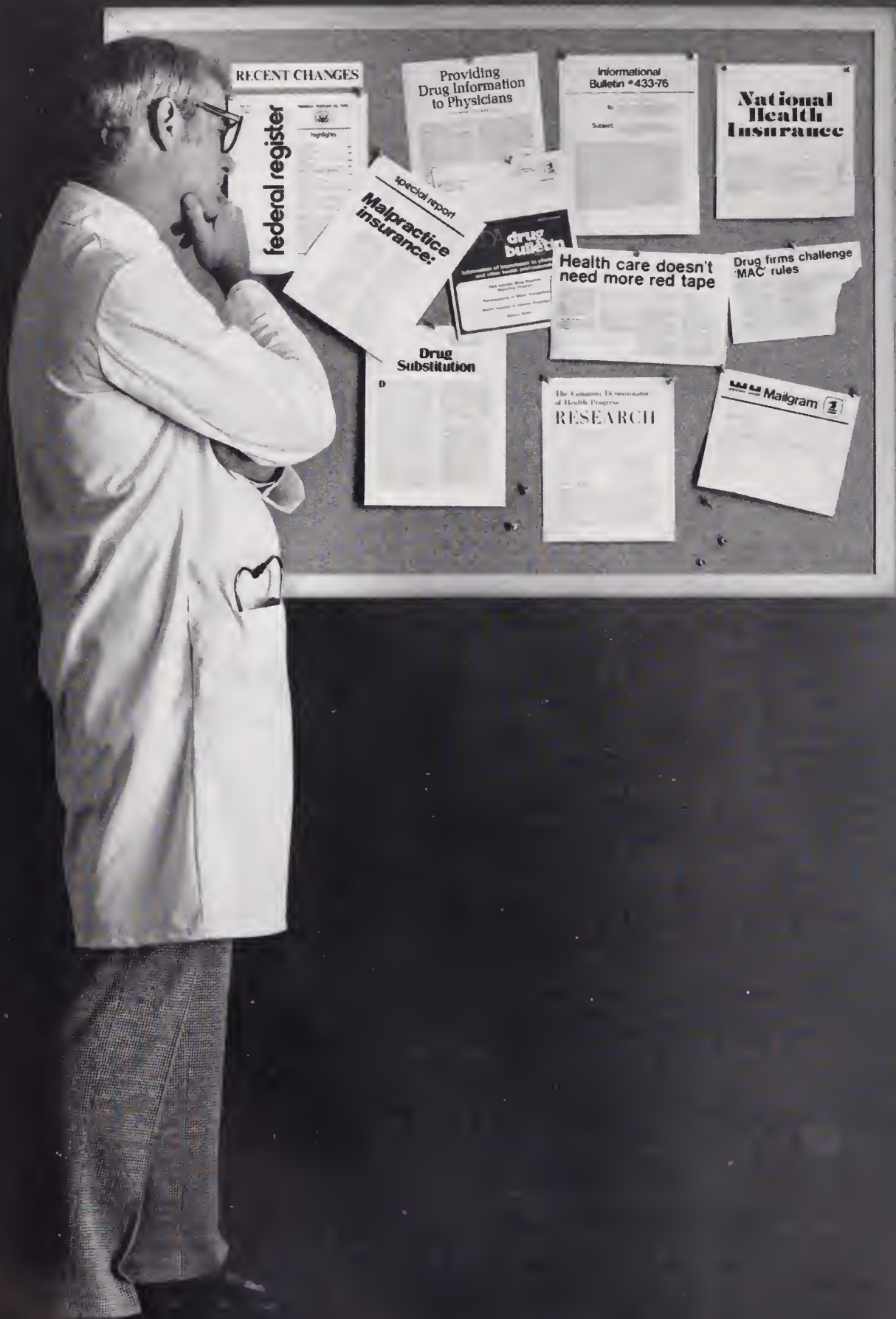
Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

Each capsule contains doxepin, as the hydrochloride, 10 mg. (NDC 0018-0356), 25 mg. (NDC 0018-0357), and 50 mg. (NDC 0018-0358) capsules in bottles of 100 and 1000.



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Drug firms challenge
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Drug
Substitution

The Common Denominator
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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
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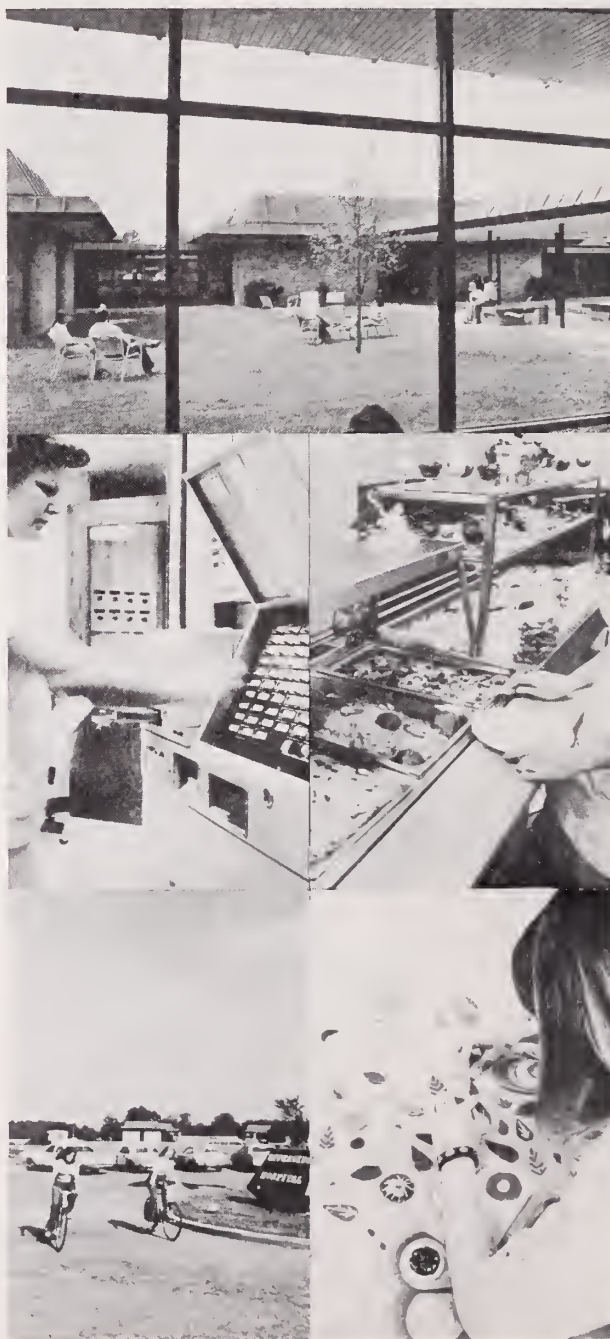
The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

For additional information contact: John R. Reedy, Executive Director.

Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030



DATELINE

Ski Trip Departs From Jackson

Jackson, MS - Arrangements have been finalized for the charter flight to the 8th annual North American Medical Dental Conference in Aspen and Snowmass, CO, Feb. 19-26.

A special Braniff 727 jet will fly direct from Jackson to Grand Junction. Cost of special flight is \$215. Optional land arrangements are available and ski lessons and rental equipment offered at special group discount for conference attendees. Space is limited; contract Travel Centre, 4537 Office Park Dr., Jackson.

Alabama Dedicates Tumor Institute

Birmingham, AL - The Lurleen B. Wallace Tumor Institute and Radiation Therapy Building at the University of Alabama in Birmingham will be dedicated on Jan. 14. The \$6.7 million,

three story research and outpatient radiation and chemotherapy treatment center is the first phase of the institute. The second phase, the Wallace Cancer Bed Tower - an 80 bed cancer hospital is scheduled to be completed in mid-1978. More than \$5 million has been contributed by Alabamians for the building.

AMA Fights Violence on TV

Chicago, IL - The AMA has announced a grant of \$25,000 to the National Citizens Committee for Broadcasting, a media reform group based in Washington, DC. The committee is

concerned with documenting the amount of television violence portrayed in prime time network television. AMA EVP James H. Sammons, M.D., said the grant "represents a strong commitment by the AMA to endorse and finance activities that will encourage the industry to reduce the amount of violence in TV programming."

New Strain of Gonorrhea Feared

Atlanta, GA - Public health officials are alarmed over a penicillin-resistant strain of gonorrhea that was first found last February in this country and has since spread to 10 states. Only one antibiotic, spectinomycin, has been found effective against the new strain. However, even spectinomycin does not cure all cases, according to Paul Wiesner, M.D., a VD control expert at the CDC. He is concerned that the new strain may develop resistance to spectinomycin, thus eliminating any protection.

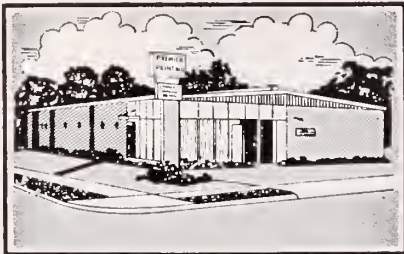
Better Hepatitis Reporting Urged

White Plains, NY - IPCO Hospital Supply Corporation has called for a multi-faceted campaign to reduce risk of hepatitis. IPCO, which serves Medical, Dental and Optical

markets, has extensive blood banking activities through its Community Blood & Plasma Service subsidiary. Campaign includes increased reliance on repeat donors; encourage rapid reporting of the disease by health departments to identify carriers; and funding of clinical research to develop more effective tests for viral hepatitis.

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PMA Establishes Drug Use Commission

A Joint Commission on Prescription Drug Use has been created under drug industry auspices and cited by Senator Edward M. Kennedy as "an important national experiment" whose success could provide a model for problem solving in such areas as energy, environment and national health insurance.

The commission, during its three year charter, will assemble drug use data, design a mechanism for postmarketing surveillance and develop a format for the periodic reporting of drug experience to the public and the medical community.

Sponsored by the Pharmaceutical Manufacturers Association, the \$250,000 a year project will be directed by a commission composed of physicians, pharmacists, pharmacologists, attorneys, hospital administrators and representatives of industry and the general public.

AMA Blasts Medicaid Report

The American Medical Association has assailed the government's release of the names of 995 physicians who last year received \$100,000 or more from the Medicaid program, terming the action "nothing less than an attempt at guilt by innuendo."

A total of 2,533 Medicaid providers, including dentists, pharmacies and laboratories as well as physicians, was released by the Social and Rehabilitation Service (SRS) of the Health, Education and Welfare Department. The agency said the list was requested under the Freedom of Information Act by news media and others. Under the act, according to the agency, the information must be provided.

"The fact that these medical providers received the stated amounts from the Medicaid program should not be construed as any evidence of wrongdoing, nor do amounts listed necessarily represent 'earnings' or 'profits,'" SRS spokesman said, adding that it had no information as to the size of staffs employed by the individual doctors, or the number of separate offices they may maintain.

AMA's Dr. Sammons asked, "Does HEW think these doctors are guilty of fraud? Then let HEW say so. Does HEW think they are guilty of violation of ethics? Then let them give us the names and we will investigate."

it's
the real
thing



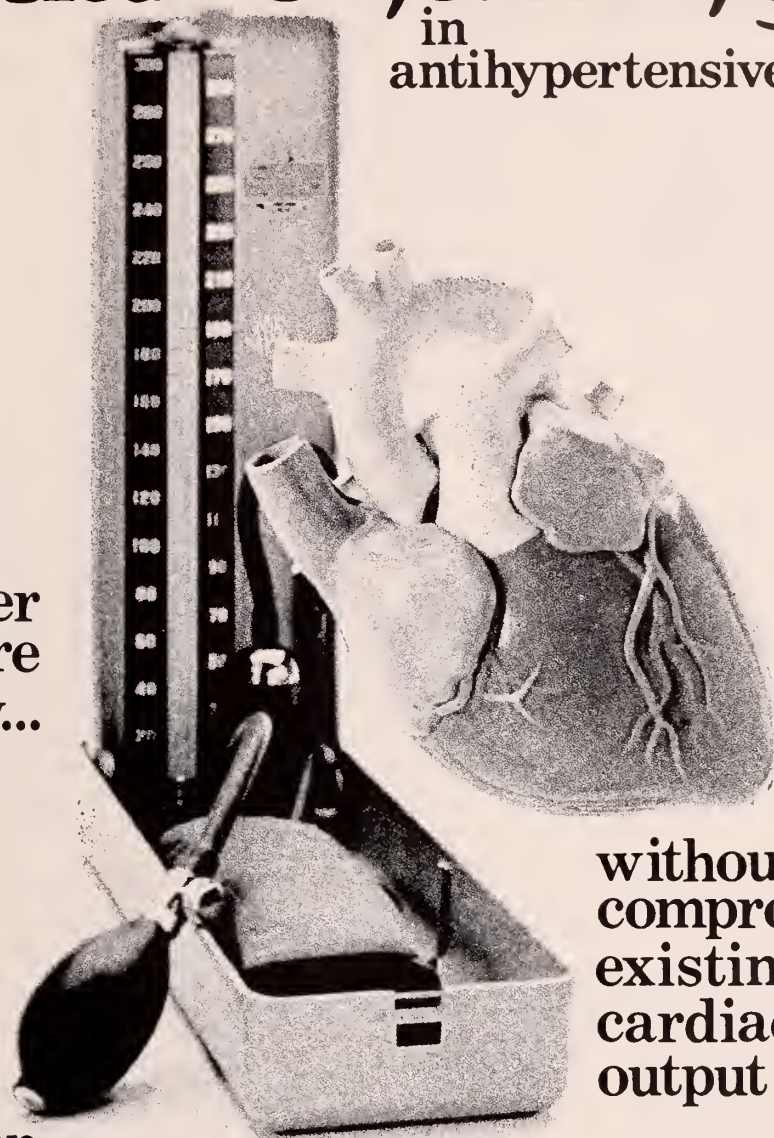
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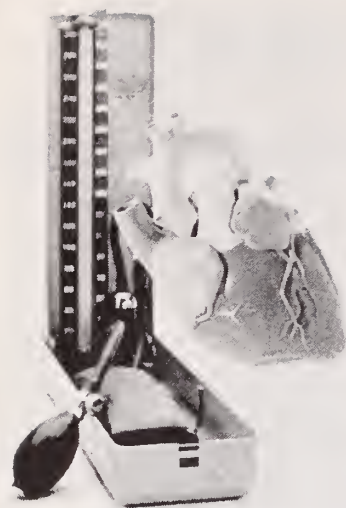
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ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders. It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

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effectively...
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direct effect on
cardiac function—
cardiac output is
usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatulence, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07 (707)

MSD MERCK SHARP & DOHME

Stricter Exams Needed for Pilots

"Airplane pilots need stricter physical examinations because medically unfit airmen continue to endanger themselves and the public," claims the General Accounting Office (GAO) in a report to Congress. Most of the criticism was directed at private pilot screening but the GAO said that even commercial pilot tests are often less thorough than those for military pilots, air traffic controllers and foreign civilian pilots.

Better medical examination requirements would be especially helpful in singling out pilots with heart trouble, alcoholism and high blood pressure, the GAO said.

The report suggested there are some 23,000 private pilots "who may represent potential safety problems, including about 12,500 with records of driving (autos) while intoxicated and 200 with physical disabilities which prevent them from driving an automobile," said the GAO.

The GAO, an investigative agency for Congress, proposed that the Federal Aviation Administration be allowed to review data of the National Highway Administration on withdrawal or denial of drivers' licenses for pilots.

Most scheduled U. S. airlines have tougher medical checks than required by federal law, but there is no requirement that the airlines notify the government when pilots with FAA medical certificates flunk their airline physicals, according to the GAO.

The GAO report and the recent publication of several books questioning airline safety and pilot reliability may lead to 1977 Congressional hearings.

Medical Practice Costs Go Up

Soaring inflation, increased malpractice premiums, and higher wages and benefits for employees are the three main reasons it costs physicians more to provide medical service today.

This is the finding of an American Medical Association poll of a cross section of American physicians seeking their opinion on why medical costs are rising and how costs can be contained. Results were published in the Impact section of the *American Medical News*, the AMA's weekly newspaper for physicians.

Nine out of 10 MDs responding to the survey say that their practice overhead costs have increased in

the past three years, with 44 per cent estimating increases ranging between 26 per cent and 50 per cent. Some 42 per cent had increases of 25 per cent or less, while the remainder found their costs going up more than 50 per cent.

Overwhelmingly, physicians (85 per cent) believe that, taking all health services costs into account, the greatest savings can be effected in hospitals. Only 6.4 per cent think substantial cost savings could be effected in medical office practice.

Many physicians say the main way to reduce costs for patients is to order fewer tests, but they point out that malpractice is forcing them to practice more defensive medicine.

Hair Transplant Symposium Scheduled

The American Society for Dermatologic Surgery and the American Academy of Facial Plastic and Reconstructive Surgery are co-sponsoring a conference on the latest advances in techniques on hair transplantation.

The meeting will be held Feb. 11-12, 1977, at the Stough Dermatology and Cutaneous Surgery Clinic, P.A., Doctors Park, Hot Springs, AR 71901. Attendance will be limited.

The multi-discipline international faculty will include dermatologists, otolaryngologists, regional and general plastic surgeons.

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Whether you're there or not, it costs the same amount of money each month to keep your office open. But, with no money coming in, it could really put you in a serious financial position. You need the businessman's insurance with your practice in mind — the MSMA PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM. It works for you when you can't. It'll pay 100% of your covered fixed overhead costs — even up to \$3,500 a month, the maximum amount available. And, the benefits are available for as long as 18 months. Premiums may be deducted as a direct business expense, too.

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ORIGINAL PAPERS

Rib Erosion and Fractures in a Patient With Progressive Systemic Sclerosis

THOMAS E. WEISS, M.D.,
NANCY TONDREAU NEELY, M.D., and
HAROLD R. NEELY, M.D.
New Orleans, Louisiana

THE RADIOLOGY literature has reported rib erosion in a small number of patients with collagen diseases, especially rheumatoid arthritis, and more recently, superior rib erosion in three cases of scleroderma.¹⁻³ This lesion has not been emphasized in other medical literature but it is apparently not uncommon in collagen disease. Superior rib erosion caused by diseases other than collagen disease, such as hyperparathyroidism, poliomyelitis, tumor at the site, osteogenesis imperfecta, Marfan's syndrome, and radiation damage, can usually be excluded clinically. The following is an additional case of erosion of the superior aspect of the posterior ribs in a patient with scleroderma. The erosion is associated with previously undescribed pathologic rib fracture.

CASE REPORT

A 38-year-old white housewife first came to the Ochsner Clinic in January 1960 (aged 23 years) complaining of cold hands since childhood, a later onset of bluish discoloration and paresthesia of the hand when exposed to severe cold, and two years of diffuse swelling of the hands. Examination of the hands confirmed the color and temperature changes. A diagnosis of Raynaud's disease was made; no specific drugs were prescribed. In March 1963 she returned with similar complaints; she had acral sclerosis and a healed ulcer on the right third fingertip. All laboratory studies at both of these visits were normal or negative.

From the Department of Internal Medicine, Section on Rheumatology, Ochsner Medical Center, New Orleans, La.

Between 1963 and 1966 she was treated for scleroderma by other physicians and was given hydroxychloroquine sulfate, potassium p-amino-benzoate, and reserpine for the Raynaud's phenomena and skin ulcers without favorable results.

A female patient, treated for approximately 15 years for various manifestations of progressive systemic sclerosis, had erosion of the superior margins of left ribs 4-7 and right ribs 3-7. Pathologic fractures of the ribs, associated with cortical thinning also occurred. Clinicians should be aware that this lesion is apparently not uncommon in collagen diseases.

In April 1972, she experienced a six month period of fatigue, pyrosis, mild dysphagia, and constipation. The skin tightness had become generalized and the fingertip ulcer, chronic. She had been taking oral corticosteroids in 1970 and 1971 and later received intravenous infusions of low molecular weight dextran every six weeks. Generalized scleroderma, with multiple fingertip ulcers, tissue atrophy of the hands, flexion deformities of the hands and elbows, decreased motion of the shoulders and hips were recorded. Hemoglobin was 11.8 gm/100 ml; erythrocyte sedimentation rate (Westergren), 38 mm/hr; uric acid, normal.

On April 23, 1972, chest roentgenogram showed obvious erosion of the superior margins of left ribs four through seven and right ribs three through seven (see Figure 1). Near each costophrenic angle there

was a suggestion of some increased interstitial markings in a subpleural location. Distal ends of the clavicle and superior cortices of the clavicles were not eroded. The hand roentgenograms showed soft tissue calcification at both thumb tips and reabsorption of the distal phalanx of the left thumb. Upper gastrointestinal studies and barium enema demonstrated 4-hour transit time and atonic colon, respectively. Aperistalsis, hiatal hernia, and positive Berstein test were found on esophageal motility studies. Technically difficult pulmonary function studies were thought to represent mild restrictive lung changes. The patient's disease was diagnosed as progressive systemic sclerosis.

In April and November 1972, she received 1 to 1.5 mg intravenous reserpine which was of little help. *Staphylococcus aureus* was isolated from one of the fingertip ulcers and she was treated successfully with doxycycline hyclate (Vibramycin), erythromycin

sterate (Erythromycin), and nylidrin hydrochloride (Arlidin) throughout 1973 when the ulcers recurred.

In July 1973, she complained of transient left anterior chest wall pain with deep inspiration. This was not incapacitating and the discomfort gradually subsided in a few weeks.

In December 1973 she was hospitalized for a fecal impaction. A posteroanterior chest roentgenogram at that time showed the left fourth, fifth, and sixth ribs were sites of fractures associated with cortical thinning (see Figure 2). The patient could recall no trauma other than straining at stool which caused a pleuritic type of pain. The degree of thinning on the right side of the rib cage seemed increased slightly from the April 1972 films. She continued to have slight left scapular discomfort with pressure on the chest or excessive motion of the left arm.

A roentgenogram in August 1974 showed progressive thinning of the ribs on the right and a fracture of the fifth rib posteriorly that seemed to be healing.



Figure 1. Erosions of the superior margins of left fourth through seventh ribs and right third through seventh ribs.



Figure 2. Rib fractures left fourth, fifth, and sixth ribs. Superior rib erosions of greater intensity than seen in Figure 1.

In August 1975 the patient was free of chest complaints. She continues to be troubled with fingertip ulcers and gastrointestinal complaints, primarily constipation. Pulmonary function studies remain unchanged; chest diameter is 69 cm in full inspiration and 68 cm in full expiration.

COMMENTS

The current concept of the cause of upper marginal rib erosion in cases such as the one described is intercostal muscle atrophy with reduced stress on the associated rib and subsequent osteoporosis and atrophy of the rib from disuse. This concept is strengthened by the finding of such a lesion in a patient with restrictive lung disease.⁴

In one of the three previously reported cases of rib erosion in scleroderma, there was some concern that the rib erosion might possibly be related to the

patient's concomitant metastatic breast cancer. Our case and reports of rib erosion in other collagen diseases would tend to support the belief that the lesion is due to scleroderma. In this case, the rib changes resulted in pathological fracture of some of the involved ribs.

★★★

1514 Jefferson Highway (70121)

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SPEAKETH THE EDITOR

Getting out a magazine is no picnic.
If we publish original matter, they say we lack variety.
If we print jokes folks say we are silly.
If we don't they say we are too serious.
If we publish things from other papers, we are lazy.
If we are out rustling news, we are wasting time.
If we are not rustling news, we are not attending to business.
If we don't print contributions, we lack appreciation.
If we do print them, the paper is full of junk.
Like as not some fellow will say we swiped this from some other
paper—
So we did!

Trabecular Gallbladder: Report of a Case

JACK B. CAMPBELL, M.D.
Jackson, Mississippi

ALTHOUGH PLINY¹ mentions the finding of a double gallbladder in a sacrificial victim in 32 B.C., the first documented description was that of Blasius² in 1674. Since that time, numerous cases and types have been reported. The practicing surgeon should be acquainted with these malformations to prevent the rare disaster to which they may lead. The reader is referred to Gross³ excellent review for a complete description of these anomalies and to Boyden⁴ for their embryology.

In 1931, Croudace⁵ reported the only known case of trabecular gallbladder. This type of double gallbladder is thought to arise from the hepatic trabeculae near the gallbladder bed with the duct from the accessory vesica communicating directly with the bile capillaries in the liver. It is this type of anomaly which is described here.

CASE REPORT

R.C., a 40-year-old white male, was seen in consultation at Hinds General Hospital with a history of abdominal pain and indigestion. Oral cholecystogram revealed a "non-functioning" gallbladder on two successive examinations. Intravenous cholangiogram demonstrated a normal common duct but the cystic duct and gallbladder were not visualized. At surgery, what was first thought to be a dilated gallbladder with a large phrygian cap was discovered. The cystic artery and cystic duct were in their usual positions. These structures were secured and further dissection of the gallbladder was begun. When the portion thought to be a phrygian cap was freed from the liver fossa, it was found to be a separate viscus joining the normal gallbladder by a narrow isthmus at its apex and with a separate short cystic duct opening directly into the liver substance. This duct drained copious amounts of normal appearing bile and was secured by a suture ligature of chromic catgut. Both gallbladders were then removed without difficulty. The

patient's postoperative course was completely without incident and following discharge, he has had no further G.I. complaints.

The author gives the recorded history of incidence of a double gallbladder. He then gives a case report of a patient with this condition seen at Hinds General Hospital in Jackson. This extremely rare congenital anomaly of the gallbladder is only the second case ever reported in the English literature, according to Dr. Campbell.

Since both gallbladders in this case contained stones, it is postulated that the apical fistula resulted from stone erosion since the two structures evidently arose from two different anlage.



Figure 1. Intact Specimen.

From the Department of Surgery, Hinds General Hospital, Jackson, MS.



Figure 2. Opened Specimen.

SUMMARY

An extremely rare congenital anomaly of the gallbladder is reported which, when added to that reported by Croudace, results in only two cases in the English literature.

Even though anomalies of the gallbladder are rare, every surgeon should be cognizant of these variations and be prepared to deal with them at the time of operation.

★★★

1828 Hospital Drive (39204)

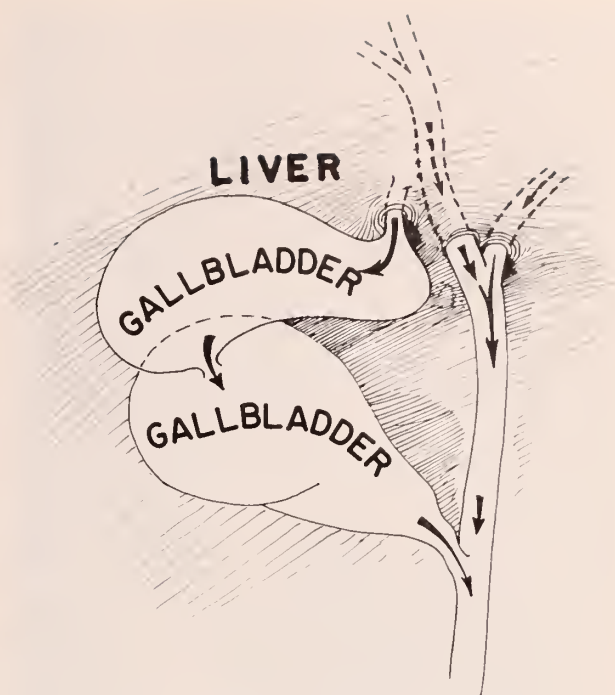


Figure 3. Anatomical Relationships.

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A MESSAGE TO PRESIDENT-ELECT CARTER

"Any president who sets foot in this town without a full briefing on dynamic inaction, decision postponement patterns and creative status quo cannot go very far."

—JAMES H. BOREN, Founder, President
and Chairperson
International Association of
Professional Bureaucrats
Washington, DC

Problems in Abdominal Surgery

VII. Fistulae of the Mesenteric Small Bowel

WILLIAM O. BARNETT, M.D.

Jackson, Mississippi

FISTULA CAN BE defined as an abnormal communication between two epithelial or mesothelial-lined surfaces. The lesion most often follows surgical intervention in relation to bowel anastomosis, inadvertent bowel injury during dissection, or the drainage of an abscess following bowel perforation as in diverticulitis or Crohn's disease. Cutaneous fistulae involving the mesenteric small bowel are rare in patients who have not experienced surgery. Richter's hernia also constitutes a possible source of bowel fistula, as the intestinal wall may perforate from necrosis without the production of obstruction.

PREVENTION

The construction of a small bowel anastomosis must always be attended by strict adherence to certain fundamental principles. Maintenance of a good blood supply is foremost among these considerations. The chance for failure in this area may be minimized by placing a clamp across the bowel at an angle so as to insure adequate circulation to the antimesenteric surface. Extensive stripping of the mesentery from the bowel in order to "clean" this surface for anastomosis must be avoided. Perhaps the most severe clinical challenge relates to assessing the viability of bowel following release of an incarcerated hernia or adhesions. There are no absolute criteria upon which this issue can be decided, so clinical judgment governs the decision. Among the helpful parameters are bowel color, pulsation of the mesenteric vessels, whether or not bleeding ensues following transection, and bowel peristaltic activity. A period of observation, during which warm, moist packs are applied, should be employed. Often, after five to ten minutes, remarkable improvement is observed and the decision is no longer doubtful. If the issue remains questionable after this period, it is better to proceed with bowel resection. Meticulous hemostasis of the divided bowel ends is desirable because hematoma formation may predispose to leakage. Also, it is my persuasion

that exposed mucosa should not be apparent after completion of the anastomosis and that precise closure of the "bare area" between the leaves of the mesentery should be achieved.

Mesenteric small bowel fistulae often follow a surgical procedure, according to the author. He explains the pathophysiologic changes which result from these lesions and discusses diagnosis, immediate assessment, management, and gives an illustrative case report.

When the peritoneal environment is fouled by bowel content or other sources of contamination, we utilize intraluminal neomycin, iodized catgut, copious irrigation, and intraperitoneal antibiotics. A dangerous circumstance exists when the patient with Crohn's disease presents with bowel perforation, abscess formation, and usually, intestinal obstruction. Past experiences have resulted in the conclusion that an ostomy should be constructed in this situation and that primary anastomosis should not be employed until later.

PATHOPHYSIOLOGY

Where adhesion formation with compartmentalization of the abdominal cavity is not extensive, bowel leakage usually results in generalized peritonitis. The inflamed peritoneal surface sheds large quantities of fluid and depletion of body stores proceeds with rapidity. Bacterial organisms may be prominent in the peritoneal cavity and may find their way into the vascular and lymphatic systems almost instantaneously. In those cases where "walling off" is achieved early, pathophysiologic problems usually relate to abscess formation and septicemia. Intestinal obstruction is frequent as a result of bowel loops becoming adherent to the inflamed mass. When effective drainage is achieved, the abscess cavity frequently contracts, a fibrous tract is formed, and ultimate closure of the bowel defect may be achieved.

Depending upon the level of the fistula, large

From the Department of Surgery, University of Mississippi Medical Center, Jackson, MS.

volumes of fluids and electrolytes may be lost to the body economy. Indeed, this problem constitutes one of the most profound challenges resulting from these lesions. The rich concentration of bile, pancreatic juice, gastric secretions, and succus entericus form a highly digestive ferment and extensive damage to the abdominal wall can be expected to follow exposure to these substances. Sepsis represents another of the concernable pathophysiologic problems resulting from fistulae. For the most part, it occurs when there is inadequate drainage with intra-abdominal pooling, stasis, secondary infection, and ultimately septicemia.

DIAGNOSIS

Where abdominal closure has been effected without employment of a drain, the existence of bowel leakage may be more difficult to determine. These patients usually complain of abdominal pain with nausea and vomiting. Temperature elevation, along with paralytic ileus are common findings. Also, abdominal tenderness and rigidity may be evident. The use of a drain has been blamed in the origin of fistulae resulting from leaking suture lines. It is my opinion that the advantages of placing a soft rubber drain outweigh the disadvantages. However, it is probably advisable to locate the tip of the drain at a point some inches removed from the suture line. Even when a drain is utilized, discharge along the tract may be delayed, because intestinal secretions are generated rather slowly during the first few days after surgery and intestinal peristalsis is relatively inactive during this period. The discharge of material along the path of a drain does not constitute positive proof of a fistula, as the situation may represent a sinus or drainage from an abscess. The administration of charcoal or methylene blue with its subsequent appearance on the abdominal wall constitutes very strong evidence in favor of fistula formation.

Radiographic Investigations. Injection of contrast media through a catheter inserted into the tract, followed by an x-ray film, frequently demonstrates the course of the fistula and the mucosal pattern of the involved bowel. These sinograms have been most helpful to us in establishing the presence of a fistula, assessing its course, and delineating the level of bowel involvement (see Figure 1). The surgeon should go to the x-ray department, and under fluoroscopic control, all cutaneous openings should be injected. Important information, which may be gained, includes whether or not a fistula is present, the level of the fistula, the presence of an abscessed cavity between the bowel and the skin, the status of bowel continuity, the presence of distal obstruction, and the condition of adjacent bowel.



Figure 1. Sinogram outlining a fistulous tract arising from a leaking anastomotic suture line between the ileum and the colon.

IMMEDIATE ASSESSMENT

In the relatively acute circumstance, it is important to evaluate the blood pressure, pulse, temperature, fluid and electrolyte status, and the level of the blood volume as rapidly as possible. Older patients are generally possessed of less reserve, engender a higher mortality, and necessitate more precise correction of deficiencies. Evaluation of cardiac, lung, and renal function should be carried out along with efforts to determine the patient's diabetic status. When the currently responsible surgeon was not involved in the initial operation, a careful review of all details concerning the previous surgery should be achieved. Of additional concern is the age of the fistula and the volume of fluid loss per 24 hours. It is also important to evaluate the nutritional status, condition of the skin of the abdomen, and whether or not a state of sepsis exists.

MANAGEMENT

Restoration of Fluid, Blood, and Electrolyte Deficiencies. A central line providing access to one of the large venous channels of the chest should be provided immediately. Fluid infusion should be guided

by the central venous pressure and by the rate of urinary output. Electrolyte and blood administration should be influenced by laboratory values. Albumin may be given where severe protein deficiencies exist.

Infection. When there is inadequate drainage, stasis, infection, and sepsis constitute items of serious concern. Where the challenge is severe, our preference for systemic antibiotics consists of one of the cephalothin preparations along with an aminoglycoside. Early concern must relate to providing efficient drainage, where stasis and infection of accumulated bowel contents has occurred.

Malnutrition. Total intravenous alimentation represents one of the major advances in the management of patients with alimentary tract fistulae.¹ Indeed, some fistulae may close without the necessity for operative intervention. Where the alimentary tract has been placed at total rest, this therapeutic modality has now been developed to the level of practical clinical application so that it should be provided for all patients with these lesions. Even where surgical correction of the fistula is ultimately necessary, the improvement in nutritional status renders the patient a much more optimal surgical risk.

In those instances where considerable small bowel absorptive surface lies proximal to the fistula, a consideration must be given to the employment of an elemental diet. These refined amino acid preparations may be given through a small nasogastric feeding tube, a gastrostomy, or an enterostomy tube.

Skin Care. Active digestive enzymes, which are especially highly concentrated in the discharge of higher level fistulae, are very irritating to the skin of the abdominal wall. Indeed, extensive skin loss with secondary infection may prove to be one of the most serious and bothersome problems in the management of bowel fistulae. Mechanical devices, such as a well-fitted bag or a sump suction apparatus, may be effective. Additional skin protection may be afforded by Karaya powder or aluminum paste. In severe circumstances, where advanced damage already exists, it may be necessary to resort to a Stryker frame so that the patient may be maintained in a prone position most of the time.

Wound Inspection. Most patients with bowel fistulae have recent surgical wounds. Close examination may provide helpful information concerning the need for drainage of a wound abscess, whether or not bowel may be seen, or whether or not there is a mucocutaneous symphysis. As a result of extensive inflammatory involvement of the adjacent bowel loops

with extensive adherence, evisceration of these wounds is unusual.

Indications for Surgical Intervention. Operative correction is necessary when there is loss of bowel substance with separation of the bowel ends. Spontaneous closure cannot be expected when there is a symphysis between the mucosa and the skin. Where a large abscess cavity exists, effective surgical drainage is usually necessary. Distal obstruction constitutes another necessity for surgical intervention. Persistent fistula drainage also results from malignant involvement, retained foreign bodies, and fungus infection. On some occasions, the cause may not be apparent, but the existence of persistent, significant drainage, regardless of the cause, may require operative management.

Fistula closure in the absence of operative management is recorded voraciously in the literature. In Dudrick's series, surgical intervention was necessary in only 18 per cent of cases, while Welch recorded a figure of 78 per cent.² This discrepancy is explainable on the basis of case selection.

Preparation for Surgery. Surgical correction of the fistula should be delayed until several items are achieved, among which are weight gain on hyperalimentation, attainable suppression of sepsis, and improved patient appearance. On an average, this requires from three to four weeks. By this time, fluid, electrolyte, and blood volume problems should have been corrected, and systemic antibiotic coverage well-established. Consideration should be given to the administration of nonabsorbable antibiotic preparation, such as neomycin, by mouth or through a nasogastric tube, for 48 hours before surgery. Preoperative placement of a long nasogastric tube may serve as a route through which irrigation of the bowel and fistulous tract with neomycin solution may be achieved. Intubation with the Miller-Abbott tube can be expected to provide technical assistance during the operation in differentiating bowel loops above and below the fistula.

Operative Management. Several surgical procedures are available for various fistula problems (see Figure 2). In most instances, with all else being equal, it is best to resect the segment of mesenteric small bowel. Partial exclusion may be more appropriate for poor-risk patients in whom a long operation is best avoided. Bypass of the defective lower ileum may be desirable because of the considerable effort necessary to mobilize this relatively fixed, narrow segment. The availability of the transverse colon with its mobility, good blood supply, etc., frequently favors its selection for the distal portion of the bypass. Complete exclusion is not desirable in most cir-

cumstances, but if it is employed, a drain must be maintained in position in order to prevent a closed, blind loop. When resection is accomplished, temporary utilization of a soft rubber drain is desirable.

SURGICAL MANAGEMENT OF SMALL BOWEL FISTULAE

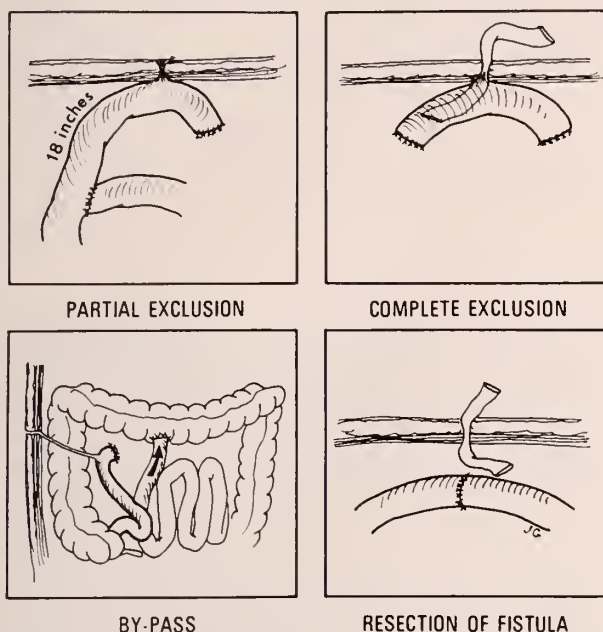


Figure 2. Various operative approaches which may be utilized for fistula management.

Mortality. There is evidence that the mortality rate for bowel fistula has decreased. An example is provided by the experience reported by Welch et al.² In 1960, their mortality rate was 44 per cent, while the similar figure in 1974 had decreased to 21 per cent. This improvement is a result of the many advancements in broad areas of surgical diagnosis and therapy.

CASE REPORT

G.D., a 51-year-old male, had abdominal pain and underwent exploratory laparotomy in December 1975. A portion of the ileum, along with the ascending colon, was resected following which the ileum

was anastomosed to the transverse colon, end-to-end. Postoperatively, he developed abdominal pain, along with fever, and it was necessary to drain an abscess on the right side of the abdomen. Drainage from the site persisted until his admission to the University Hospital in March 1976. Sinogram revealed a fistula which arose from the site of the previous anastomosis (see Figure 1).

After satisfactory preoperative preparation, the abdomen was opened and numerous dense adhesions were encountered. A small catheter was passed through the fistulous tract and was noted to enter the bowel at the site of the previous anastomosis. This portion of the ileum and colon was resected following which an end-to-end anastomosis was constructed, utilizing normal-appearing colon and ileum. During the postoperative period, it was necessary to treat an abscess which formed in the skin near the cutaneous opening. Subsequently, he has experienced no problems related to this condition.

SUMMARY

Mesenteric small bowel fistulae most often follow a surgical procedure. Pathophysiologic changes which result from these lesions include fluid and electrolyte depletion, sepsis, skin damage, and malnutrition. The diagnosis is suspected when significant drainage appears from an incision or drain site, skin irritation is observed, administered dye or other substances appear on the abdominal wall, and a sinogram reveals access of injected contrast material to the bowel mucosa. Recovery of these patients is encouraged by restoration and maintenance of fluid and electrolyte levels, optimal drainage to control sepsis, total intravenous administration, protection from skin damage, and the judicious employment of surgical intervention.

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CROSSING SPECIALTY LINES

As two surgeons were leaving the operating room, one turned to the other and said, "That was close. An inch either way and I would have been out of my specialty."

—*Journal of the Medical Association
of the State of Alabama*

Radiologic Seminar CLXVI: Positive Posterior Fat Pad Sign of the Elbow

Indicating Significant Elbow Injury
Even in the Face of No Visible Fracture

PHIL O. NELSON, JR., M.D.
Laurel, Mississippi

IN THE JUVENILE skeleton, injuries of the elbow that are not grossly evident on radiographs can be most difficult to interpret accurately and errors are apt to lead to maltreatment and serious sequelae. Injuries of the elbow require the most expert diagnosis and treatment.

Fractures of the elbow often bleed into the joint distending the joint capsule. The swollen joint capsule displaces the fat pad in the olecranon fossa posteriorly so that it becomes clearly visible on the lateral radiograph of the elbow made with the elbow flexed 90° (see Figure 1). Normally one does not see this fat shadow. The fat that is radiographically visible appears to be extracapsular in location as well as some fat incorporated in the joint capsule

but external to the synovial layer. Flexion of the elbow helps in displacing this fat pad posteriorly in the presence of hemorrhage into the joint.

The most common fracture of the humerus is the supracondylar fracture in which the fracture line is often horizontal. If the fracture is not displaced it may be undetectable on the routine radiographs. Also, radial head and other fractures of the elbow may not be detectable on initial radiographs. The positive fat pad sign seen posterior to the distal humerus (see Figure 1) will certainly be of help in detecting these injuries so that proper treatment can be instituted. It is very important to recognize that these injuries which can lead to serious sequelae in the way of deformities and disabilities may show only subtle radiographic abnormalities initially. Follow-up films in seven to 10 days usually demonstrate the fracture location.

★★★

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Jones County Community Hospital, Laurel, MS.

P.O. Box 607 (39440)



Figure 1. Positive posterior fat pad sign. A child with a supracondylar fracture picked up because of joint hemorrhage displacing the olecranon fossa fat pad posteriorly.



MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 18-23, San Francisco. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

La.-Miss. O. and O. Society, Mar. 10-13, 1977, Biloxi. Arthur Hays, M.D., Secy., 3017 13th St., Gulfport 39501; Ben Davis, Executive Secy., P.O. Box 12314, Jackson 39211.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 6-9 1977, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 109th Annual Session, May 2-5, 1977, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Henry McCrory, Secy., P.O. Box 340, Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. G. L. Arrington, Jr., Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1167, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Thomas Glasgow, Secy., 1196 Mound St., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. James H. Sams, Secy., 321 Hospital Drive, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Clyde Gunn, Jr., Secy., P.O. Drawer G, Moss Point 39563. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Thomas Blake, Secy., 424 S. 13th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.



The President Speaking

This Is Your Mississippi State Medical Association

LYNE S. GAMBLE, M.D.
Greenville, Mississippi

THE MISSISSIPPI State Medical Association was founded in 1846 “. . . to advance the art and science of medicine . . . and promote the public health. . . .” It is the oldest professional association in Mississippi. The association seeks to provide a forum and a collective voice for the medical profession in Mississippi on professional and public health matters. Interestingly enough, in this regard, one of the first acts of the association when it was organized in the mid 1800’s was to implement a program for the people of the state “. . . to express the importance of a more perfect system of drainage upon plantations to prevent . . . grave forms of fever.”

The association’s 1600 physician members comprise some 90 per cent of the state’s practicing physicians. Membership is attained through one of 18 local component medical societies. The association is governed by a 160-member House of Delegates elected by the membership.

The Mississippi State Medical Association along with the other state and territorial medical associations comprise the American Medical Association. The AMA is governed by a House of Delegates similar to that of MSMA. AMA Delegates are apportioned in accordance with total membership in the individual states. MSMA presently has two AMA delegates who are elected by the MSMA House of Delegates.

“What has the Mississippi State Medical Association done for me?” or “Why should I join the Mississippi State Medical Association?” are logical questions for a physician in Mississippi to ask. Of course, the first response to this is that any association, and particularly a professional association, is a reflection of what the membership wants it to be and is willing to work to accomplish. So the first response to “Why join?” or “What has it done?” might be “What do you want from your professional association?” and “What have you done to accomplish it?” But this aside—the Mississippi State Medical Association because of the interest, work and commitment of its membership has done much for both the profession and the public in Mississippi.

Let’s list a few “recent happenings” keeping in mind that the Mississippi State Medical Association has been in existence since 1846 as your professional association—

- Did you know that the \$7,500 tax deductible retirement contribution you can set aside each year or that the pro-

(Continued on page 13)

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVIII, NUMBER 1
JANUARY 1977



EDITORIALS

National Health Insurance

Now that the smoke of the political campaign has cleared, many physicians view with apprehension the future of medical practice in our nation. Prior to the election, two-thirds of all physicians favored the reelection of President Ford, based mainly on Mr. Carter's endorsement of a program of national health insurance. They feared a comprehensive NHI would interfere with the physician-patient relationship and intensify the aggravations experienced with Medicare and Medicaid.

Of major concern to all citizens is the cost of a national health plan. Out of many plans suggested, the two major contenders are the federally-sponsored Kennedy-Corman Bill, financed by tax dollars, funded by premiums, payroll taxes, and income taxes, and secondly, a coinsurance-deductible plan financed by out-of-pocket payments by individuals.

It has been estimated by the Congressional Budget Office that total national spending for personal health services by 1981 will be \$252 billion if no NHI is instituted. Estimate of the cost of the Kennedy-Corman plan in 1981 is \$289 billion, but this depends on the effectiveness of cost controls proposed in the bill. An article by Mitchell and Schwartz in the October 14 issue of the *New England Journal of Medicine* discusses "Strategies for Financing National Health Insurance." It would cost Americans about \$50 billion per year in increased prepayments if a combination of premium, payroll taxes, and income taxes is used for financing. If the coinsurance-deductible method is used, the additional cost would be approximately ten billion dollars. The use of taxes rather than premiums would result in a large share of the cost being borne by the higher income groups, in which category most physicians fall.

In January, President Carter will outline his proposal for national health insurance to the Congress. If he can please medicine, labor, special interest groups, and Congress, it will be a miracle. Here's hoping!

GEORGE H. MARTIN, M.D.
Associate Editor
Vicksburg, MS

The President Speaking

(Continued)

Professional corporation you can form in Mississippi are only available because of efforts of the American Medical Association and the Mississippi State Medical Association respectively, or

- Did you know that just two years ago most family health insurance contracts sold in Mississippi excluded newborn coverage. In 1973 the MSMA House of Delegates discussed this perplexing matter affecting many young couples and went on record in support of corrective action by the Mississippi legislature. By the way, you should really thank your ob-gyn and pediatric colleagues for their interest and work to get this accomplished.
- Maybe you didn't know either that the Uniform Health Insurance Claim form that is only required in Mississippi and several other states was sought and obtained by the association as a result of interest and work by members of a local component medical society. In case you don't remember, you and your patients once had 50-100 different claim forms for your "use," or

- Did you know that some states now *require* CME as a condition for annual renewal of a license to practice medicine? Our professional association is now in the process of establishing a *voluntary* program of CME for physicians in Mississippi.
- Did you know that there is a Mississippi Medical Political Action Committee that was sponsored by the association in 1963 for the purpose of political education and support of candidates favorable to medicine? A number of your colleagues recently gave their time and money to MPAC activities in support of candidates for the 1976 Mississippi Legislature and 75 per cent of those candidates were elected.
- Finally, did you know that there is a professional liability insurance crisis and National Health Insurance debate going on at this time, the solutions to which will determine your future as a physician? Did you know that the Mississippi State Medical Association and the American Medical Association are trying to participate in these solutions—do you care?

★★★

Medico-Legal Brief

NO NEGLIGENCE FOUND IN BREAST REDUCTION SURGERY

A jury instruction on *res ipsa loquitur* was not warranted where evidence failed to support a finding that postoperative complications of breast surgery could not have occurred in the absence of negligence, a Florida appellate court ruled.

A patient consulted a surgeon with regard to having her breast reduced. With the patient's consent, the surgeon performed a reduction mammaplasty, employing the Strombeck technique. This technique was used to maintain the circulatory system in the breasts, thus reducing postoperative necrosis.

In a 2½-hour operation, the surgeon removed more than 1,500 gm. of tissue. Postoperatively, the patient lost 30 per cent more breast tissue because of impaired circulation, with a result that she had scarred, unevenly shaped breasts.

The patient brought a malpractice action against the surgeon, contending that he misapplied an accepted surgical technique. The jury decided for the surgeon.

The patient appealed, contending that the trial court erred in failing to give a requested instruction on *res ipsa loquitur* to the jury. To be entitled to an instruction on *res ipsa loquitur*, the appellate court said, the patient must show that circumstances eliminated every conclusion except that the physician was at fault.

Although evidence indicated that the patient's necrosis was the result of impaired blood circulation in her breasts after the operation, her proof did not support a finding that the circulation impairment would not have occurred unless the surgeon failed to exercise due care, the court said. Affirming the trial court judgment, the appellate court found that there was substantial evidence to support the verdict. —*Anderson v. Gordon*, 334 So.2d 107 (Fla. Dist. Ct. of App., April 13, 1976; rehearing denied, July 6, 1976)



PERSONALS

RONALD P. BOREN announces the opening of his office for the practice of pediatrics at Doctors Park, 105 Hillcrest Drive, Houston.

RICHARD C. BORONOW announces the relocation of his office to Medical Plaza Building, Suite 304, 1600 North State Street, Jackson, for practice limited to gynecologic oncology. Dr. Boronow recently co-authored a book, *Gynecologic Oncology*, published by John Wiley and Sons in 1976. Other authors are Drs. Felix Rutledge and J. Taylor Wharton.

NAN C. BRANTLEY has opened her office for the practice of general psychiatry and group psychotherapy at 1060 Riverside Plaza, Jackson.

MICHAEL BROOKS announces the opening of his practice of ENT at 1203 Jefferson Street, Laurel.

F. H. BAIR, III, C. B. FERGUSON and R. P. TATE announce the opening of their offices, Marshall County Doctors Clinic, adjacent to the hospital in Holly Springs.

ROBERT L. COBB of Ocean Springs has been certified by the American Board of Internal Medicine.

SIDNEY A. CHEVIS of Bay St. Louis has been named chief of staff for 1977 at Hancock General Hospital. Other appointments included MARION J. WOLFE, SR., vice chief of staff; J. B. LEVENS, secretary-treasurer; and WILLIAM E. CALVERT and HELEN G. MCGEHEE, staff members.

RUBY GRIFFIN announces the opening of her office in the old hospital, West Side Entrance, in Calhoun City.

ARMIN F. HAERER of Jackson and UMC presented a paper at the National Commission on Epilepsy southern regional meeting in Atlanta.

JAMES D. HARDY of Jackson and UMC gave the Founder's Lecture on the current status of organ replacement at the North Pacific Surgical Association meeting in Spokane, WA.

W. BRIGGS HOPSON of Vicksburg is new president of the West Mississippi Medical Society. Other officers are M. E. HINMAN, secretary; LEO SCANLON, vice president; and KARL HATTEN and TOM MITCHELL, MSMA delegates.

JACK C. HOOVER of Pascagoula has enrolled in the Patrons of Excellence program of the Mississippi State University Development Foundation.

CHARLES R. JENKINS of Laurel was named the Honor Alumnus for 1976 at the homecoming banquet of the Jones County Junior College and Agricultural High School Alumni Association.

WILLIAM C. KELLUM of Tupelo has been elected to fellowship in the American College of Physicians.

S. S. KETY of Picayune was honored with a special meeting of the honorary fraternity of the American Legion to which he has devoted many years of service.

THOMAS L. KILGORE, JR., of Jackson has been named a fellow of the American College of Cardiology.

TOM MAYER of McComb was guest speaker at the recent meeting of the McComb Rotary Club. He discussed the work of the health department and how the private sector assists the department in its work.

ROGER C. MURRAY has associated with JOHN D. DYER of Houston in the practice of general and vascular surgery at Doctors Park, 105 Hillcrest Drive in Houston.

FRANCIS S. MORRISON of Jackson and UMC presented an invited lecture on transfusion therapy at St. Mary's Hospital Graduate Medical Center in Evansville, IN.

JOHN PORTER of Brookhaven addressed the New-comers Club at their recent meeting.

GEORGE D. PURVIS of Jackson has been honored by Mississippi College with the "Service to Humanity" award.

An appreciation day was held on Nov. 28 at the National Guard Armory to honor M. E. SHAHEEN of Como for his many years of unselfish and devoted service to his fellowman.

WALTER H. SIMMONS of Jackson announces his withdrawal from the Simmons Clinic for Women and the reopening of his offices at 320 St. Dominic's Medical Arts Building, effective Feb. 1, 1977.

HORTON TAYLOR of Ripley spoke on how to cope with stress and anxiety at the community-service mental health program sponsored by the Tippah County Mental Health Association.

CLIFFORD TILLMAN of Natchez spoke on newer concepts of coronary care at the Adams County Heart Association District 1 meeting.

W. MICHAEL VISE announces the opening of his office for the practice of neurosurgery at Mississippi Methodist Rehabilitation Center at 1350 E. Woodrow Wilson Drive in Jackson.

W. B. WHITE announces the resumption of family practice at Community Annex-Doctors Clinic, S. Magnolia Street at Mason in Laurel.



NEW MEMBERS

BLEDSON, ROBERT E., Greenville. Born Maud, MS, Oct. 5, 1921; M.D., Duke University School of Medicine, Durham, NC, 1951; interned John Gaston Hospital, Memphis, TN, one year; residency in ob-gyn, same, 1953-56; elected by Delta Medical Society.

BONDURANT, SIDNEY W., Philadelphia. Born Philadelphia, MS, Sept. 19, 1946; M.D., Vanderbilt University School of Medicine, Nashville, TN, 1971; interned University of California, Sacramento, one year; elected by East Mississippi Medical Society.

BOSTWICK, FRANK HINES, Jackson. Born Ripley, MS, Nov. 11, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned University of Miami, Miami, FL, one year; pathology residency, Medical College of Georgia, Augusta, one year; pathology residency, University Medical Center.

NEW MEMBERS / Continued

Jackson, MS, one year; pathology residency, University of Southern California, 1970-72; elected by Central Medical Society.

BRADFORD, WILLIAM W., Pascagoula. Born New Orleans, LA, Sept. 19, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned Mobile General Hospital, Mobile, AL, one year; emergency medicine residency, Louisville Medical Center, Louisville, KY, 1974-76; elected by Singing River Medical Society.

BRUCE, JAMES A. JR., Oxford. Born Kosciusko, MS, April 21, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned St. Joseph Hospital, Houston, TX, one year; ophthalmology residency, University of Tennessee, Memphis, TN, 1973-75; elected by North Mississippi Medical Society.

BURRIS, RICHARD G., Brookhaven. Born McComb, MS, June 2, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned Charity Hospital, New Orleans, LA, one year; elected by South Central Medical Society.

HAND, WILLIAM L., Meridian. Born New Orleans, LA, June 7, 1939; M.D., Tulane University School of Medicine, New Orleans, LA, 1965; interned McLeod infirmary, Florence, SC, one year; surgery residency, Ochsner Foundation Hospital, New Orleans, LA, 1968-72; fellowship in hip surgery, New England Baptist Hospital, Boston, MA, Jan. 1972-July 1972; elected by East Mississippi Medical Society.

HASSELL, JOHN F., Jackson. Born Moss Point, MS, Oct. 30, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned and family medicine residency, University Medical Center, Jackson, MS, 1973-76; elected by Central Medical Society.

LYERLY, DONALD N., Oxford. Born Memphis, TN, Nov. 23, 1939; M.D., University of Tennessee College of Medicine, Memphis, 1964; interned City of Memphis Hospitals, Memphis, one year; general surgery residency, Baptist Hospital, Memphis, one year; orthopedic surgery, Campbell Clinic, Memphis, 1969-71; elected by North Mississippi Medical Society.

MCNEIL, JACK A., Greenville. Born Jackson, MS, Aug. 31, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned St.

Elizabeth Medical Center, Dayton, OH, one year; ob-gyn residency, Miami Valley Hospital, Dayton, OH, 1973-76; elected by Delta Medical Society.

MILES, CHARLES DAVID, Columbus. Born Bruce, MS, Oct. 26, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned and ob-gyn residency, same, 1970-73; elected by Prairie Medical Society.

NELSON, GARY A., Clinton. Born Miami, FL, April 4, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned Mobile General Hospital, Mobile, AL, one year; elected by Central Medical Society.

SMITH, ROBERT ALLEN, Jackson. Born Poplarville, MS, July 21, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned and general surgery residency, 1969-71; otolaryngology residency, same, 1971-74; residency in plastic surgery, University of Tennessee, Memphis, 1974-76; elected by Central Medical Society.

TOLER, MERT C., JR., Clarksdale. Born Greenwood, MS, Dec. 12, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned, same, 1974-75; elected by Clarksdale and Six Counties Medical Society.

WILSON, ROBERT M., Tupelo. Born Monticello, MS, April 26, 1935; M.D., University of Mississippi School of Medicine, Jackson, 1966; interned and anesthesiology residency, same, 1966-69; elected by Northeast Mississippi Medical Society.

YATES, ALLEN RICHARD, Jackson. Born Memphis, TN, Oct. 5, 1944; M.D., University of Tennessee College of Medicine, Memphis, 1969; interned Grady Memorial Hospital, Atlanta, GA, one year; radiology residency, University Medical Center, Jackson, MS, 1972-75; elected by Central Medical Society.



LETTERS

SIRS: For a biography of Dr. Alton Ochsner of Ochsner Clinic, New Orleans, opinions, evaluations, anecdotes, reminiscences, and photos are needed. Photos will be carefully handled and returned. All material will be gratefully received.

IRA HARKEY, Ph.D.
401 Metairie Road, 706
Metairie, LA 70005

SIRS: One of the puzzling dilemmas of our technological times is that frequently when we approach a problem we cannot be sure that the "cure" is not worse than the problem itself. The present controversy of the ravages of the fire ant through the southern states versus the possible hazards of the insecticide Mirex is just such a dilemma. Since Mirex is at present the most effective control measure against the spreading fire ant, this kind of technological problem remains sharply in focus.

The Environmental Protection Agency announced recently a decision it had reached to begin phasing out Mirex by the end of 1977 unless some convincing statistics can be compiled which will show that there are many more plus than minus factors in the use of the insecticide.

I would like to survey my fellow physicians and health services personnel of the states affected by the fire ant problem as to their findings regarding either or both horns of this particular dilemma. To this end, I would greatly appreciate answers to the following series of questions by all those in the know who have time and energy to spare to the problem:

1. How many individuals have been stung by fire ants in your area, region, or state? Can you estimate a probable number? State sex.
2. What kind of reactions to fire ants have you seen? Local reactions? How great was the swelling? Larger than an inch? Larger than 4 to 6 inches? Did swelling involve a joint? More than 1 joint? Systemic reactions? What symptoms? (Underline symptoms if present.) Wheezing, hives, angioedema, urticaria, laryngeal edema? How soon did symptoms occur? How long did they last? Superimposed infection? Does this occur often? Are such infections severe?
3. Have patients reacting to fire ants required hospitalization? If so, how many and for approximately how long?
4. To your knowledge, have there been any fatalities to fire ant stings in your area, region, or state? If so, how many? Could you provide details?
5. If you have any case histories of reactions to fire ant stings, they would be greatly appreciated. They should include age, sex, race, symptoms, treatment, and outcome.
6. Have you any knowledge as to the success or failure of hyposensitization to fire ant venom? If so, details would be appreciated.
7. To your knowledge have there been any cases of Mirex poisoning and/or illnesses attributed

to the use of Mirex in your area, region, or state? If so, could you provide information about such incidents? Case histories, if available, about such illnesses would be greatly appreciated. They should include age, sex, race, symptoms, treatment and outcome.

8. Have you a personal opinion about this particular problem? Do you believe the possible hazards of fire ants outweigh the possible hazard of the use of Mirex? Or vice versa.

CLAUDE A. FRAZIER, M.D.
Doctors Park—Bldg. 4
Asheville, NC 28801



POSTGRADUATE CALENDAR

Jan. 10-11, 1977

Feb. 7-8, 1977

NEWBORN RESUSCITATION

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine, the School of Nursing and the University Medical Center Division of Continuing Health Professional Education.

Coordinator:

Gwendolyn Bussa, M.N., assistant professor of nursing, the University of Mississippi School of Nursing.

Open to physicians, RNs and respiratory therapists, the two-day course will emphasize the manual skill of resuscitation with lectures and practice. UMC faculty will stress management of the mechanical and pharmacological needs of the resuscitated newborn, and how to identify the neonate in need of resuscitation. Enrollment is limited to six. Another session is planned for May 23-24 at the Medical Center. Fee: \$50. Credit: 15 contact hours, 1.5 CEU, Category I, AMA; AAFP.

Jan. 13-14, 1977

NEWBORN VENTILATION

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine, the School of Nursing and the Medical Center Division of Continuing Health Professional Education.

Coordinator:

Gwendolyn Bussa, M.N., assistant professor of nursing, the University of Mississippi School of Nursing.

UMC faculty will teach the anatomy and physiology, indications and practical problems of newborn ventilation in this two-day course for physicians, RNs and respiratory therapists. Emphasis is on the initiation, maintenance and nursing care of the newborn on artificial ventilation. Another session is planned for May 26-27 at the Medical Center. Fee: \$50. Credit: 14 contact hours, 1.4 CEU, Category I, AMA; AAFP.

Jan. 17-21, 1977

ELECTROCARDIOGRAPHY INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:

Thomas M. Blake, M.D., professor of medicine, University of Mississippi School of Medicine

This week-long course for physicians includes discussions and demonstrations related to clinical electrocardiography. It is designed for practicing clinicians, internists, or family practitioners who use electrocardiography in their daily work. The intention of the course is to enhance understanding of the subject, its limitations and its applications. Instruction will emphasize principles, perspectives, and insight rather than electrophysiology. The present state of instrumentation will be discussed with emphasis on the role of the computer. Participants are encouraged to bring problem tracings for discussion. Fee: \$125. Credit: 40 contact hours, 4.0 CEU. Category I, AMA; AAFP.

Jan. 19-21, 1977

PSYCHIATRY INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:

James G. Williams, M.D., associate professor of psychiatry and human behavior, University of Mississippi School of Medicine

This two and one-half day course for physicians stresses the practical aspects of psychiatry. Diagnosis of the major psychiatric syndromes using videotaped examples will aid participants in making office diagnoses. Instruction will include discussion of newer psychiatric drugs and a rational approach to the better use of older psychiatric drugs. Little time will be spent on hospital treatment. Instead, the course will concentrate on outpatient counseling, drug therapy, referral skills, and how to use the family as a therapeutic ally. Fee: \$65. Credit: 20 contact hours, 2.0 CEU, Category I, AMA; AAFP.

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers intensive refresher courses to meet physicians' clinical practice needs in the specialties most requested. Mississippi Regional Medical Program partially supports the series open to all physicians. Intensive courses are eligible for AMA Physician Recognition Award, Category I, credit. Enrollment is limited, and applications are accepted in the order received. All correspondence about intensive and other courses should be addressed to Continuing Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

FUTURE CALENDAR

March 2-4, 1977

OTOLARYNGOLOGY

University Medical Center, Jackson

March 9-11, 1977

NEWBORN CARE FOR PHYSICIANS

University Medical Center, Jackson

March 10-12, 1977

SURGICAL FORUM IV

Holiday Inn Downtown, Jackson

March 17-19, 1977

ACUTE NEUROLOGY-NEUROSURGERY INTENSIVE COURSE

University Medical Center, Jackson

March 21-23, 1977

HEMATOLOGY INTENSIVE COURSE

University Medical Center, Jackson

March 23-25, 1977

ONCOLOGY INTENSIVE COURSE

University Medical Center, Jackson

March 28-April 1, 1977

PEDIATRICS INTENSIVE COURSE

University Medical Center, Jackson



Book Review

A New Vaccine for Child Safety. By Murl Harmon, M.B.A., M.A. 252 pages with illustrations. Jenkintown, Pa.: Safety Now Co., Inc., 1976. \$7.50.

This book covers many aspects of child safety, stressing prevention from start to finish. It is a good book for parents and prospective parents that we as physicians could recommend in good faith. Each chapter centers on one general area of accident prevention, making it easy to refer to as occasions arise. For those not wishing to read the entire book, the last chapter is a general review. The appendix also lists 37 other sources of information on safety and contains a list of poison control centers in each state.

Accident prevention is a subject of which too few parents are aware and this book projects ideas which, if followed, would make a child's environment a safer place.

PAUL B. WELCH, M.D.
Jackson, MS

SBH Emergency Medical Services Seminar Set

The first statewide seminar on emergency medical services has been set for Jan. 14-15 in Jackson to present current trends in emergency medical care.

The seminar, sponsored by the Division of Emergency Medical Services, Mississippi State Board of Health, and the Northeast Mississippi Emergency Medical Services Authority, is the first of its kind in this state and will feature many outstanding dignitaries including Governor Cliff Finch and Dr. David Boyd, national director of the Division of Emergency Medical Services with the U. S. Department of Health, Education and Welfare.

According to Wade Spruill, division director for the MSBH, the theme of the seminar is "Emergency Medical Services—It's More Than a Ride to the Hospital."

The Technical/Clinical Workshop will feature leading physicians discussing the role of the emergency room physician, post traumatic respiratory problems, unconscious patient—head injuries or other

problems, neonatal emergencies, multiple injured patients, burns—a total body problem.

The Programmatic Workshop will feature discussions concerning the various pieces of federal and state legislation relating to emergency medical services systems in the state as well as the roles played by the Health Systems Agency, the National Highway Traffic Safety Act, and the Appalachian Regional Commission.

The EMT/Paramedic Allied Health Professional Workshop will feature discussions concerning Mississippi EMT certification, the national registry, the role of the EMT in the health care team, EMT—a new professional, treatment techniques of behavioral disorders, drug overdoses, and the mobile intensive care paramedic.

According to Spruill, the seminar will be held at the Holiday Inn-Downtown. The registration fee of \$10 will include meals and workshop materials. Hotel reservations should be made directly with the hotel.

Physicians, nurses, emergency medical technicians, public officials, and citizens who are interested in emergency medical services are encouraged to attend the two-day meet.

For further information, contact the Division of Emergency Medical Services, Mississippi State Board of Health, Box 1700, Jackson, MS 39205.

MSMA Will Bring Suit

The Mississippi State Medical Association will seek a "quo warranto" action against two physicians appointed to the Mississippi State Board of Health by Governor Cliff Finch in apparent violation of Section 41-3-1, Mississippi Code of 1972.

The physicians, Dr. Howard A. Clark of Morton and William A. Middleton of Winona, were appointed to the Board by Governor Finch even though they were not among nominees of the association submitted in accordance with Section 41-3-1.

A "quo warranto" action under Mississippi law is an action to remove from office a person who is serving illegally.

Medicaid's Program for Children Called a Disgrace

The Southern Regional Council, headed by Ms. Patricia Derian, former chairperson of the Mississippi Loyalist Democrats and now a member of President-elect Carter's transition team in health matters, has called the Medicaid screening and treatment program for children "a national disgrace and an inexcusable waste of human resources." Jackson, Mississippi, was cited as one of several areas studied.

The council's criticism of Medicaid's health program for children established by Congress in 1967 echoed findings last fall of a House subcommittee on health "that mismanagement of the program by the Department of HEW had caused unnecessary crippling, retardation or even death of thousands of children."

The program for children in poverty level families was intended to provide a means for screening, diagnosing and treating early childhood medical conditions through public and private health care resources.

The council report stated that many physicians were not participating in the program because of low Medicaid payments for services, heavy paperwork and long delays in receiving payments. The council urged HEW to establish clearer program guidelines, to adopt stiffer penalties for states that don't follow the guidelines, and to encourage more health care facilities in poverty neighborhoods.

Tri-State Thoracic Case Conference Set

Twelve speakers from medical centers throughout the United States will be featured at the 21st annual Tri-State Thoracic Consecutive Case Conference to be held Jan. 14-15, 1977, at the Hilton Hotel in Biloxi.

Dr. Walter Treadwell of Jackson, president of the Mississippi Thoracic Society, announced that the two-day event, a postgraduate session for physicians of Mississippi, Louisiana, and Alabama, is sponsored by Lung Associations and Thoracic Societies of the Tri-State area.

Mississippi physicians featured on the program include Dr. Roland B. Robertson, Jr. of Jackson, who

will also serve as moderator; and Dr. H. Karl Stauss, also of Jackson.

Dr. Donald Greenberg, professor of pathology, Baylor College of Medicine, Houston, TX, will deliver the keynote address at 1:00 p.m. Friday, Jan. 14.

Guest essayists for the conference include Dr. Donald E. Paulson, chief of thoracic surgery, Baylor Medical Center, Dallas; Dr. Louis Raider, clinical associate professor of radiology, University of Southern Alabama Medical School, Mobile; Dr. Robert M. Rogers, professor of medicine, University of Oklahoma Medical School, Oklahoma City.

Other program participants are Dr. Dick D. Briggs, Dr. John N. McAtee, and Dr. C. Edward Rose, all of Birmingham; Dr. Hurst B. Hatch, Dr. John B. Blalock, and Dr. Frank Alessi, all of New Orleans.

Topics to be presented include: "Complications of Ventilatory Support in Acute Respiratory Care," "Infectious Diseases," "The Clagett Procedure in Close Space Problems," "Comparison of Mediastinoscopy and Mediastinotomy in Patients with Bronchogenic Cancer," "Consecutive Cases of Emphysema" and "Consecutive Cases of Transbronchial Biopsy."

For registration information, write Mississippi Thoracic Society, P. O. Box 9865, Jackson, MS 39206.

Mississippi Physician Sues HEW

A \$10,000 lawsuit against the Department of Health, Education and Welfare (HEW) filed in U. S. District Court at Biloxi charges that Mississippi physicians receive "substantially lower" Medicare fees than other doctors across the nation.

Dr. John B. O'Keefe of Biloxi filed the suit and said that although state doctors perform the same medical services, they are being paid less.

O'Keefe contends that doctors elsewhere are being paid more for equivalent services than Mississippi doctors.

The doctor claims he has lost nearly \$29,000 since Medicare was enacted in 1965, but he is seeking only \$10,000 in damages.

HEW allegedly has paid less in medical fees to doctors in Mississippi because of a lower standard of living in the state.

The suit contends that HEW's payment practices discourage doctors from working in less populated areas of the country and in Mississippi in particular.



MSMA Board of Trustees Holds Regular Fall Meeting

The MSMA Board of Trustees conducted its regular fall meeting in Jackson during December and dealt with a number of matters to include approval of the association's 1977 budget, review of a public information campaign about the malpractice crisis to be sponsored by the association beginning in late December, review of current plans to form the Mississippi Medical Fraternal and Educational Society, and action on gubernatorial appointments to the Mississippi State Board of Health made in apparent violation of Mississippi law.

The Board approved a 1977 association budget of \$646,560. The budget includes expenses and income for the association's programs as CHAMPUS fiscal administrator for professional services in Mississippi and as data processor for the Mississippi Foundation for Medical Care-PSRO Program. MSMA programs and services for the membership will account for over two-thirds of the 1977 budget.

A public information campaign about the malpractice crisis as approved by the House of Delegates at the 1976 Annual Session will commence in late December and run during the 1977 Regular Session of the Mississippi Legislature. The campaign will utilize the television, radio and newspaper media and will be directed at getting public understanding of the malpractice crisis and public support for legislative solutions to the crisis.

The Board reviewed the status of two appointments to the Mississippi State Board of Health made

by Governor Cliff Finch in apparent violation of Section 41-3-1 Mississippi Code of 1972 requiring appointees to come from nominees made by the association. The Board acted to institute legal proceedings to remove the appointees from the Board of Health.

A status report on the formation of the Mississippi Medical Fraternal and Educational Society was presented to the Board. The society began a membership information campaign in November and materials were mailed to all MSMA members in this regard.

In other action the Board conducted its annual review of the association's group insurance programs for the membership and Mr. Thomas A. Yates, administrator of the programs, met with the Board. Information about new programs and benefits will be mailed to the membership. The Board also acted to implement an accounts receivable management program for those members of the association who expressed an interest in participating in the program and to provide a hospital discharge abstract program to Mississippi hospitals and their medical staffs. Both programs will be self-supporting.

The Board concluded its meeting by reviewing plans for the association's co-sponsorship of a "Quality of Life Conference" to be conducted in Jackson, May 15-17, 1976. Other co-sponsors will be the University of Mississippi School of Medicine, the National Foundation, the Junior League, and the Mississippi State Board of Health.

Sen. Theo Smith's Proposal Is Rapped

Senator Theodore Smith's annual legislative proposal that UMC graduates either practice in Mississippi or pay the state \$50,000 has drawn fire from the American Medical Association.

Noting that Smith's proposal is similar to ones offered in a few other states, Dr. William Ruhe, director of the AMA's Division on Medical Education, stated that such proposals "would amount to indentured servitude and should be challenged as unconstitutional if passed by a state legislature."

The AMA supports contracts for students on scholarships to practice in rural areas, Dr. Ruhe said, because "a scholarship student has an option to sign with his eyes open from the beginning an agreement that he will practice in a rural area after graduation. But when you have no choice, as in the case of Senator Smith's proposal, it becomes a form of indentured service."

Senator Smith who as chairman of the Mississippi Senate Public Health Committee has supported such proposals for Mississippi's health problems as licensing chiropractors is expected to introduce his pay-back bill in the 1977 state legislature.

"Doublespeak Awardee Responds"

The U. S. State Department is not letting its "doublespeak" award go unnoticed. The department received the "doublespeak" award from the National Council of Teachers of English for an announcement that its consumers affairs coordinator would "review existing mechanisms of consumer input, thru-put and output, and seek ways of improving these linkages via the consumer communication channel."

The department has responded: "I think (the award) is an enormous compliment since it demonstrates remarkable recognition of ability to handle input, output and thru-put with remarkable facility recognizing the normal inability of the bureaucracy to do anything in a manner which would merit an award for anything."

Dr. James Hughes Named UMC Orthopedics Chief

Dr. James L. Hughes, Jr. became the chief of the division of orthopedics in the Department of Surgery at the University of Mississippi Medical Center Jan. 1.



Dr. Hughes

Appointment of the former Johns Hopkins orthopedic surgeon was announced by UMC Vice Chancellor Dr. Norman C. Nelson on approval of the Board of Trustees of Institutions of Higher Learning.

Dr. Hughes, 39, succeeds Dr. E. Frazier Ward, former acting chief of the division who remains on the faculty as

assistant professor of surgery (orthopedics).

On the staff of the Mississippi Methodist Rehabilitation Center in 1976, Dr. Hughes was on the Johns Hopkins School of Medicine faculty from 1967 to 1975.

The new orthopedics chief and associate professor of surgery (orthopedics), is a graduate of Mississippi College and Bowman Gray School of Medicine. He took his orthopedics training at Johns Hopkins. Other specialty training includes fellowships at the University of Basel and University of Berne, Switzerland, in 1970 and 1971.

Dr. Hughes is board certified in orthopedic surgery, a fellow of the American College of Surgeons, and has served as consultant to numerous hospitals and the East Baltimore Health Plan. While in the U. S. Army Medical Corps for two years, Dr. Hughes served as general surgeon of the 7th Surgical Hospital in Vietnam in 1966-1967.

His research deals with development and use of orthopedic implants.

Dr. Jack Stokes Guest UMC Lectureship Established

The University of Mississippi School of Medicine Class of 1960 has established a new guest lecturer program at the Medical Center as a memorial to the late Dr. Jack Avery Stokes of Pontotoc.

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E A R

I N G I S

A S P R E C I O U S

A S S I G H T H A V E

Y O U H A D Y O U R H E A R I N G

T E S T E D L A T E L Y A S I M P L Y

C O M F O R T A B L E H E A R I N G

I N V E S T M E N T O F A F E W M I N U T E S

Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
4201 West Victoria Street, Chicago, Illinois 60646, an American company

Beltone
WHEN A HEARING
AID WILL HELP



WHEN
BURNING PAIN
COMPLICATES
ACUTE
CYSTITIS*

TURN IT OFF WITH

AZO GANTANOL[®]

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

FOR THE PAIN,

- Quickly relieves painful symptoms such as burning and pain associated with urgency and frequency.
- Recommended antibacterial therapy: up to 3 days with Azo Gantanol, then 11 days with Gantanol (sulfamethoxazole).

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura,

FOR THE PATHOGENS

- Effectively controls susceptible pathogens such as *E. coli*, *Klebsiella-Aerobacter*, *Staph. aureus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

*nonobstructed, due to susceptible organisms

hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

DYAZIDE[®]

Each capsule contains 50 mg. of Dyrenium[®] (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

Trademark

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*

**LOWERS
BLOOD
PRESSURE**

**CONSERVES
POTASSIUM**

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

*** WARNING**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

*** Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with

cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K⁺ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy. Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium[®] (triamterene, SK&F Co.), and

leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
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CODEINE COMBINATION PRODUCTS.
YOU MAKE THE CHOICE.



**EMPIRIN[®]
COMPOUND
c̄ CODEINE
#3**

Each tablet contains:
codeine phosphate, 32 mg (gr ½),
(Warning: May be habit-forming);
aspirin, 227 mg; phenacetin, 162 mg;
and caffeine, 32 mg.



**EMPRACET[™]
c̄ CODEINE
#3**

Each tablet contains:
codeine phosphate, 30 mg (gr ½),
(Warning: May be habit-forming);
and acetaminophen 300 mg.



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

UMC Vice Chancellor Dr. Norman C. Nelson said the Stokes Memorial Visiting Professorship will rotate through the medical school departments, beginning in 1977.

Dr. Stokes was a family physician in Pontotoc at the time of his death in June 1974. A navy veteran, he earned his bachelor of science degree at Ole Miss in 1957 and his M.D. at the Medical Center in 1960. He completed internship training at University Hospital in 1961 and entered private practice in Pontotoc where his wife and their two children still live.

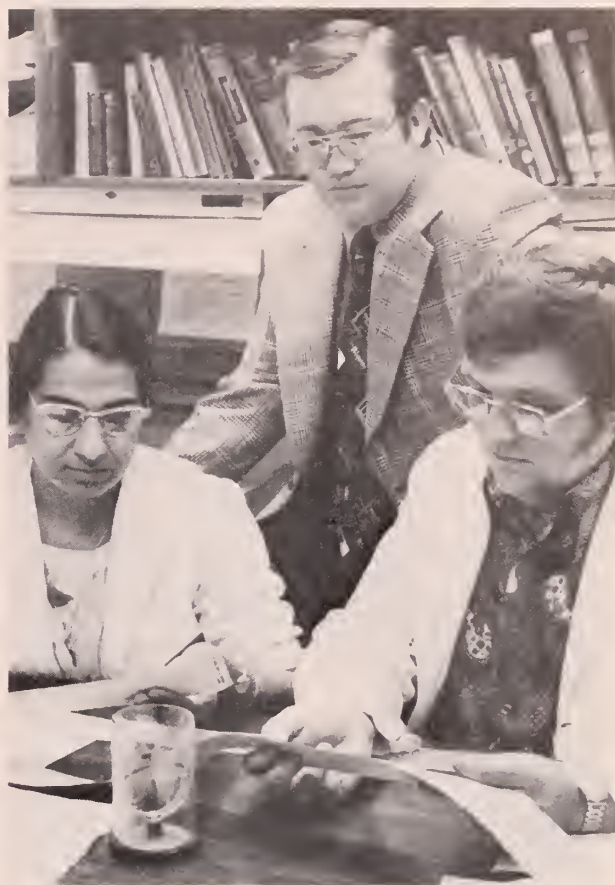
Dr. William J. Gillespie of Jackson is chairman of the Stokes Memorial Visiting Professorship committee for the UMC Class of 1960. Other members are Dr. Dewitt Grey Crawford of Louisville, Dr. John Y. Gibson of Jackson and Dr. William M. Hilbun of Meridian.

Physicians Study Hematology at UMC



Family physicians at the University of Mississippi Medical Center for an intensive course on hematology included, seated, from left, Dr. Rita C. Heidisch of Long Beach, Dr. M. V. Green of Holly Springs, and, standing, Dr. Lloyd F. LoCascio of New Orleans, LA, Dr. Judson F. Lloyd of Natchez, and Dr. John R. Harper of Taylorsville. The Medical Center Division of Continuing Health Professional Education sponsored the two-day course, with an optional third day for additional study. Mississippi Regional Medical Program provided partial support.

Physicians Attend Medical Center Workshop



Among physicians who updated their skills in a University of Mississippi Medical Center course on electrocardiography were, left, Dr. Nasim A. Aziz of Port Gibson, Dr. Jerry K. Lewis of Birmingham, AL, and Dr. Orby Lynn Hamblin of Calhoun City. The Medical Center Division of Continuing Health Professional Education offers a series of intensive refresher courses for physicians with support from Mississippi Regional Medical Program.

UMC Scientists Get Lung Association Grants

Two University of Mississippi Medical Center scientists have received research grants totaling \$9,100 from the Mississippi Lung Association.

Dr. H. M. Mehendale, assistant professor of pharmacology-toxicology, and Dr. M. D. Hardy, Jr., pulmonary medicine fellow, are the recipients.

Dr. Mehendale's study is to determine the ability of the lung to form epoxides of aldrin. He will

measure the aldrin epoxidase activity in an isolated perfused rabbit lung preparation as well as in a sub-cellular *in vitro* preparation.

"Aldrin is used as a model for chemicals which are epoxidized. Once aldrin enters the blood stream through the lung, it is epoxidized to dieldrin. Other possible carcinogenic chemicals which enter the body may also be epoxidized to carcinogenic forms," he said.

Dr. Hardy's study is designed to examine the effects of methylprednisolone on leukocyte adenylylase activity and pulmonary function in patients with severe asthma.

"In asthmatics, cyclic nucleotides are known to be present in abnormally low concentrations," Dr. Hardy said. "We know steroids partially correct the deficiency, but we don't know exactly how or to what degree."

He will use special lung function tests to record the changes in airways obstruction of severe asthmatics being treated with steroids. Blood and urine tests will be done at the same time to measure changes in the cyclic nucleotides.



Two University of Mississippi Medical Center scientists, Dr. M. D. Hardy, Jr., a pulmonary medicine fellow, left, and Dr. H. M. Mehendale, assistant professor of pharmacology-toxicology, have received Mississippi Lung Association grants totaling \$9,100 to study certain chemicals which may help or harm the lung.

Medical Center Scientist Gets ACS Grant

A University of Mississippi Medical Center scientist has a two-year \$100,000 American Cancer Society research grant to study arabinosylthymine's (or araT) effectiveness against herpes viruses.

"Chicken pox (shingles) has been shown to be a major cause of death for cancer patients on chemotherapy," microbiology professor Dr. Glenn Gentry said. "And there are strong indications of a link between the herpes simplex virus venereal disease and cervical carcinoma in women."



Dr. Glenn Gentry, professor of microbiology at the University of Mississippi Medical Center, has a \$100,000 American Cancer Society research grant to study arabinosylthymine's effectiveness against herpes viruses.

First discovered in the 1950's, araT is a natural byproduct of salt water sponges and can be produced synthetically. Although it did not turn out to be the anti-cancer agent scientists hoped it would be, the drug did show promise in preventing the growth of herpes viruses, the UMC investigator said.

According to Dr. Gentry, araT's advantage is its probable non-toxicity to uninfected cells when taken systemically.

Other drugs capable of killing the viruses have only limited use as a local medication because of their danger to healthy cells if taken internally, Dr. Gentry said. Since the viral source is usually remote from the outward manifestation, a systemic drug can be more effective than a local one.

ACS research grants are made possible through donations to state affiliates such as the Mississippi Division of the American Cancer Society.

Dr. Edgar Draper Named to Psychiatric Board

Dr. Edgar Draper, professor of psychiatry and human behavior and chairman of the department at the University of Mississippi School of Medicine, has been appointed to the American Psychiatric Association Consultation and Evaluation Services Board.

He was one of two new members named to the prestigious eight-man board at the group's annual meeting.

A consultant to the psychiatry education branch of the National Institutes of Mental Health, Dr. Draper joined the Medical Center faculty in 1975. He is an American Board of Psychiatry and Neurology examiner and a member of the Society for the Scientific Study of Religion, and the International Association for Suicide Prevention.

Dr. Draper will serve a three-year term on the APA Consultation and Evaluation Services Board, which provides consultation services to state mental health systems, community mental health centers, and hospitals.

The board also offers special services in treatment of the mentally ill, the mentally retarded, drug abusers, alcoholics, and criminal offenders.



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IN CONCLUSION

The Hemophilia Program of the Mississippi State Board of Health will pay for medical and hospital expenses related to any inherited bleeding disorders and includes payments for all blood products for these patients, according to Dr. Francis S. Morrison, chairman, SBH Hemophilia Advisory Board. Program is administered through Mississippi Crippled Children's program. To be eligible, patient must apply through the local health department. Contact Mrs. Carolyn Runyon, Social Service Supervisor, SBH (354-6680) for information.

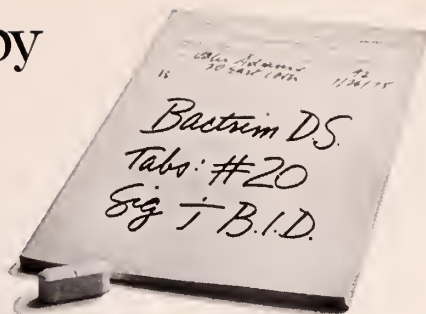
Despite the benefits of home health care, both in terms of cost and patient well-being, the home-care movement faces some serious problems. The Oct. 25 issue of U.S. News & World Report cites estimates by the American Public Health Association that at least 10-25 per cent of persons in institutions could live at home if services were available. A 1975 government survey showed only half of the communities in U.S. have appropriate home health agencies. Recent changes in Medicare benefits have even caused a decline in number of home-care patients in the last year.

Training paralegal advocates who will provide legal assistance to the mentally handicapped and developing a program of community education directed to the needs of mental patients are the objectives of a three-year project funded by HEW's National Institute of Mental Health. Primary goal of the University of Massachusetts Legal Studies Program is to train students interested in mental health to act as paralegal advocates for patients' rights. Project will deal with question of comprehensive training for paralegals in an institutional system changing to community-based.

Women doctors are doing their full share of caring for patients, along with being wives and mothers, a survey in the Detroit area indicates. Of women MDs surveyed by a Wayne State University research group, 84 per cent were engaged in medical work, most of them fulltime. Only 7 per cent were not working for reasons related to being a woman, notably staying home to care for children and household. Some of those not working were retired or disabled, as age range of survey was 30-86 years. More than half were in private practice, primary care specialties and board certified.

Blue Cross Association is conducting a study that could lead to the inclusion of broad based insurance coverage for comprehensive treatment of alcoholism and alcohol abuse in Blue Cross plans across the nation. Association is assessing feasibility of plans offering a broad-based alcoholism benefits package, covering both inpatient and outpatient treatment and use of nonhospital facilities for dispensing care. Association president W. J. McNerney, said, "As with other health problems, alcoholism demands the best attention available."

10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions noted in this study were mild (e.g., vomiting, nausea, rash), more serious reactions can occur with these drugs. See manufacturer's product information for complete listing. Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

BactrimTM DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)
Double Strength tablets
Just 1 tablet B.I.D.

BactrimTM

(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris* and *Proteus morganii*.

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema

multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-flavored — bottles of 16 oz (1 pint).



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

In a multicenter study of patients with chronic or frequently recurrent urinary tract in

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2 EAST 103RD ST
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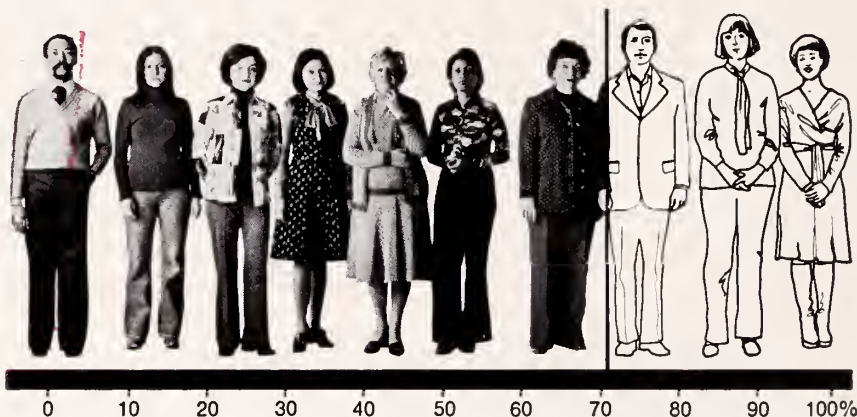
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Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†

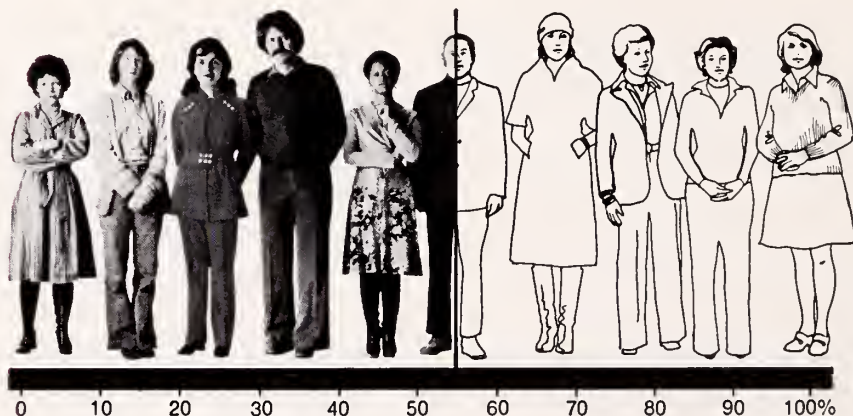
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OF MEDICINE



Bactrim—70.5% of 78 patients infection-free at 8 weeks.



ampicillin—55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

BactrimTM DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets Just 1 tablet B.I.D.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Please see summary of product information on preceding page.

ROCHE

JOURNAL

OF THE

MISSISSIPPI
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FEBRUARY 1977

From Lilly/Dista Research

NALFON[®]
*fenoprofen calcium***300-mg.* Pulvules**[®]Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206*Additional information available to the profession
on request.*

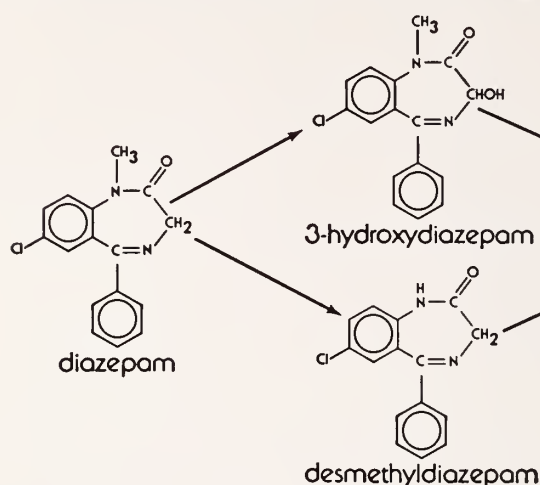
*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate
equivalent to 300 mg. fenoprofen.

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Trichobezoar, Professional Competence*



A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) ^{IV}

2-mg, 5-mg, 10-mg scored tablets
**a prudent choice in psychic
tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due

to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Nutley, New Jersey 07110

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■ TO HELP PAY YOUR PERSONAL EXPENSES, THERE'S MSMA'S INCOME PROTECTION PROGRAM

When you're not practicing, your income stops. Just paying your everyday expenses could run into a great deal of money, draining your savings, especially if your income were cut off indefinitely. The **MSMA INCOME PROTECTION PROGRAM** can pay as much as \$2,000 a month income replacement benefits payable for up to **LIFETIME** for accident-caused disabilities, **TO AGE 65** for disabilities resulting from illness. And, you choose when you want the benefits to begin — either the 31st or the 91st day of disability — to give you the coverage that best fits your own individual needs.

■ TO HELP PAY BUSINESS COSTS, PROFESSIONAL OVERHEAD EXPENSE PROTECTION'S FOR YOU

Whether you're there or not, it costs the same amount of money each month to keep your office open. But, with no money coming in, it could really put you in a serious financial position. You need the business-man's insurance with your practice in mind — the **MSMA PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM**. It works for you when you can't. It'll pay 100% of your covered fixed overhead costs — even up to \$3,500 a month, the maximum amount available. And, the benefits are available for as long as 18 months. Premiums may be deducted as a direct business expense, too.

WANT TO KNOW MORE? WRITE TODAY!

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THESE PLANS ARE MSMA SPONSORED

The **INCOME PROTECTION PROGRAM** and the **PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM** are officially sponsored and endorsed by the Mississippi State Medical Association exclusively for its members.

Also sponsored by the MSMA are the **HOSPITAL MONEY PLAN**, **MAJOR MEDICAL PLAN**, **EXCESS MAJOR MEDICAL PLAN**, and **TERM LIFE INSURANCE**. Brochures for these programs are also available.

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109th Annual Session

BILOXI, MISSISSIPPI

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MAY 2-5, 1977



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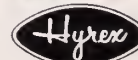
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Composition: Each sugar-free compressed tablet contains glyceryl guaicolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaicolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. **HOW SUPPLIED:** White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. Literature Available: On request.

Available through all drug wholesalers.



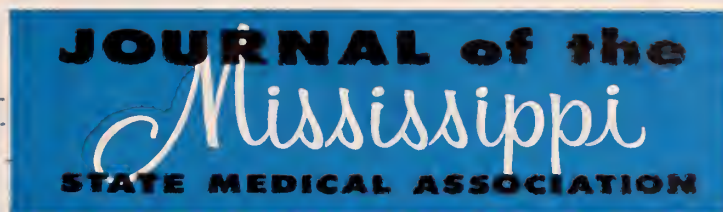
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Volume XVIII

Number 2

February 1977



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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$15.00 per annum; \$2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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Set for May 2-5 at Biloxi

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Each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer), 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer), and 25 mg phenobarbital in the immediate release layer

Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

See next page for brief summary.

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CAUTION: Federal law prohibits dispensing Tedral SA without prescription.

Description. Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

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Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

Tedral Elixir is convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

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Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to one-quarter Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

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STORE BETWEEN 59° and 86°F (15° and 30°C).

Full information is available on request.

Menstrual Disorders Are Studied

The University of Tennessee Center for the Health Sciences College of Medicine will present a symposium on Endocrine Causes of Menstrual Disorders Mar. 16-18 at the Hilton Inn, Memphis.

The program has been approved for 20 elective hours by the AAFP. For more information write Division of Continuing Education, UTCHS, 800 Madison Avenue, Memphis, TN 38163.

M. D. Anderson Offers Mammography Training

The University of Texas System Cancer Center, M. D. Anderson Hospital and Tumor Institute offers a formal course in "Mammography Training for the Early Detection of Breast Cancer" on a continuing basis. Presented under the aegis of the American College of Radiology and the National Cancer Institute (Contract #NO1-CN-55250), the course provides continuing education for practicing radiologists, radiologists-in-training, residents, other interested physicians, and technologists, registered or in-training, in film mammography, xeroradiography, or thermography. The program is under the supervision of Gerald D. Dodd, M.D. and David D. Paulus, M.D.

Held semi-monthly for five continuous days, 35 total course hours, the course includes lectures, audiovisual presentations, participation in routine patient examinations, review of teaching files and proven case materials, and daily round table discussions. The curriculum may be adapted to individual trainee's previous experience and future needs. No registration fee is required. Credit is approved for Category I, AMA Physicians Recognition Award, American College of Radiology, hour for hour; evidence of continuing education, American Society of Radiologic Technologists, one point per hour.

Courses have been scheduled through June 1977.

Physician courses begin on Feb. 7, Feb. 14, Mar. 21, April 4, April 18, May 9, May 16, June 6 and June 13.

For further information write to: Dawn Nevling Shull, Department of Diagnostic Radiology, The University of Texas System Cancer Center, Texas Medical Center, Houston, TX 77030.

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TABLETS, 20 mg.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg. per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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NEWSLETTER

February 1977

Dear Doctor:

Four MSMA component medical societies are now participating in the funding of Guyton loans as annual programs. A Guyton loan is \$500 and is provided to medical students of financial need who are native Mississippians and in the sophomore, junior or senior classes. A small interest charge is added from the date of loan until it is repaid within three years after completion of training. Societies making grants are Central, Delta, Northeast and South Mississippi.

All societies are invited to participate during this giving period (July 1, 1976-June 30, 1977) to expand financial assistance resources for medical students. The Guyton fund is sponsored by University Medical Center, MSMA, and University of Mississippi Alumni Association.

AMA members could save as much as \$1,526 a year on their insurance plans reports a recent study conducted by W. M. Mercer, Inc., AMA insurance consultant. Study compared individual insurance plans with the membership insurance program available through AMA. Firm sought coverage from outside companies for a "hypothetical" physician at age 46, then drew comparisons with AMA rates.

According to the Mississippi Hospital Association January newsletter, a recent bulletin released by the Tennessee Hospital Association notes that the Mississippi Nurses Association was among a grouping of eleven southern state nurses associations that filed LM-2 reports in order to be classed as a labor organization.

North Carolina physicians will receive professional liability insurance rate reductions from the "captive program" initiated by the North Carolina Medical Society last year. The reductions, amounting up to 27 per cent, are possible because current claim statistics indicate that insurance industry projections were "overly pessimistic," according to the president of the N.C. plan.

The U.S. Supreme Court has refused to review a decision by the Florida Supreme Court which upheld that state's Medical Malpractice Reform Act. Among other things, the act makes it mandatory for a complainant to submit his claim to a pre-trial screening panel before filing a lawsuit. A similar proposal is before the Mississippi legislature.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Trauma Seminar Scheduled for Tampa

The second annual Suncoast Trauma Seminar, a continuing education course for physicians and residents, will be held Mar. 9-11, 1977, at the University of South Florida College of Medicine, Tampa, FL.

The course is sponsored by the American College of Surgeons Committee on Trauma, and co-sponsored by the Department of Surgery, University of South Florida College of Medicine.

Course director is Roger T. Sherman, M.D., professor of surgery and chairman, Department of Surgery, University of South Florida College of Medicine.

The course, offering a comprehensive program of continuing education in the definitive treatment of the seriously injured, is designed to enhance the knowledge and skills of physicians who are first confronted with trauma patients in rural, suburban and urban hospitals.

Course curriculum will include such trauma topics as: blood volume replacement, monitoring the severely injured patient, thoracic trauma, vascular in-

juries, management of infection in the trauma patient, metabolic response to trauma, eye injuries, fractures and dislocations of the spine and pelvis, and priorities of the multiple injury patient.

The course has a limited registration of 200. Fee for physicians is \$125; for residents, \$75. Advance registration forms may be obtained by writing to Dr. Sherman at the Department of Surgery, University of South Florida College of Medicine, Box 16, 12901 North 30th Street, Tampa, FL 33612, or by writing the ACS Trauma Division, American College of Surgeons, 55 E. Erie, Chicago, IL 60601.

South Central Blood Banks Will Meet

The 19th Annual Meeting of the South Central Association of Blood Banks will be held Mar. 16-19, 1977, at the Camelot Inn, Little Rock, AR.

For additional information, contact: Executive Secretary, South Central Association of Blood Banks, 4300 N. Lamar Blvd., Austin, TX 78756.

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Donnagel with paregoric equivalent
For diarrhea

Each 30 ml. contains:

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Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
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(equivalent to paregoric 6 ml.)	
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Sodium benzoate	60.0 mg.
(preservative)	
Alcohol, 5%	

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DON'T WALK
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THIS BRIDGE



CLEAR THE TRACT

in coughs of colds,
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clear the tract
with the famous
Robitussin® Line!

The 5 members of the Robitussin® family all contain the expectorant, guaifenesin, to help clear the lower respiratory tract. Guaifenesin works systemically to help stimulate the output of lower respiratory tract fluid. This enhanced flow of less viscid secretions promotes ciliary action and makes thick, inspissated mucus less viscid and easier to raise. As a result, dry, unproductive coughs become more productive and less frequent.

For productive and unproductive coughs

Robitussin®

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For severe coughs

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Each 5 ml teaspoonful contains:

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Codeine Phosphate, USP 10.0 mg
(warning: may be habit forming)
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Non narcotic for 6-8-hour cough control

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Each 5 ml teaspoonful contains:

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Decongests nasal passages and sinus
openings as it helps relieve coughs

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Each 5 ml teaspoonful contains:

Guaifenesin, NF 100 mg
Pseudoephedrine
Hydrochloride, NF 30 mg
Alcohol, 1.4%

Decongestant action helps control cough and
clear stuffy noses and sinuses. Non narcotic.

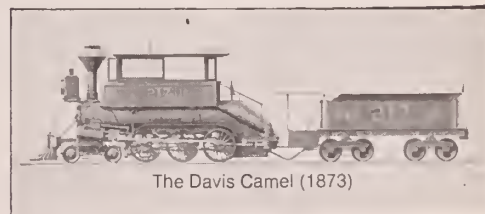
Robitussin-CF®

Each 5 ml teaspoonful contains:

Guaifenesin, NF 50 mg
Phenylpropanolamine
Hydrochloride, NF 12.5 mg
Dextromethorphan
Hydrobromide, NF 10 mg
Alcohol, 1.4%

All Robitussin formulations available on your
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For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives . . . accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The Davis Camel (1873)

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Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal[®] contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

RC/RD PD JA 1699-2-P (8 76)

When it's pinworms, treat the family



Povan[®] (pyrvinium pamoate)

- over 17 years of proved clinical effectiveness and safety
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- one dose—one time—that's all that's usually required
- two dosage forms: Tablets and Suspension—suitable for the entire family

Povan—there's a form for every member of the family.

PARKE-DAVIS

DATELINE

ABFP Diplomates Get Recertified

Indianapolis, IN - Nearly 1400 American Board of Family Practice diplomates sat for medicine's first recertification exam on October 29. Their goal was to retain ABFP diplomate status, which they earned six years ago by passing the specialty's premiere certification exam. According to ABFP officials, the five-hour testing process went smoothly at all six sites -- Denver, Chicago, New York, New Orleans, Dallas and San Francisco.

Advertising Is Fought by AMA

Chicago, IL - The American Medical Association and the American Dental Association have filed as "friends of the court" in the case of two attorneys appealing to the U.S. Supreme Court a decision by the Arizona Supreme Court allowing unrestricted advertising of attorneys' fees. The AMA states that advertising in the sophisticated field of medicine raises considerations quite different from the advertising of consumer products and simple services.

President Carter's Health Priorities

Washington, DC - President Jimmy Carter is now expected to emphasize hospital cost controls and fraud and abuse crack-downs in federal programs as his administration's initial health priorities in 1977. Unemployment and the financial problems of the cities have placed national health insurance on the back burner and plans now call for any NHI program to be phased in over several years. He does favor a comprehensive program of NHI with universal, mandatory coverage.

AMA Introduces "Medicredit" Bill

Chicago, IL - Three key members of Congress have introduced the AMA's National Health Insurance proposal. They are Representatives Tim Lee Carter (R-Ky), John J. Duncan (R-Tn), and John M. Murphy (D-Ny). The proposal (H.R. 1818) is patterned after the AMA "Medicredit Bill" which was introduced during the last Congress. Senator Clifford P. Hansen (R-Wy) is expected to introduce the measure in the United States Senate.

Health Care Spending Rises

Washington, DC - Health care spending in the U.S. reached \$139.3 billion in fiscal 1976, an increase of \$17 billion or a 14 per cent increase over 1975. An annual study, "National Health Expenditures," published by the Social Security Administration's Office of Research and Statistics, noted that these outlays cover personal health care, public health programs, research and facilities construction. In the two years since price controls expired, health care expenditures have risen \$33 billion.

Aspen Radiology Conference Scheduled

The Seventh Annual Aspen Radiology Conference, designed for physicians and scientists interested in diagnostic radiology, nuclear radiology and diagnostic ultrasound, will explore the impact of clinical and technological advances on radiologic practice Feb. 28-Mar. 4, 1977, at the Aspen Institute for Humanistic Studies, Aspen, CO.

The topics for discussions will include advances in bone, cardiovascular, gastrointestinal, ob/gyn and neuroradiology involving a tri-radiological approach. The advances in the three radiological subdivisions relating to these topics will be surveyed as refresher courses in independent diagnostic radiology, nuclear radiology and diagnostic ultrasound sessions. Instructive cases, illustrating these subjects and previewed by the conference, will be presented for open discussion in the afternoons.

Significant changes programmed for the 1977 meeting include an independent course in diagnostic ultrasound and a plenary session on total body CT scanning, comparing this modality with diagnostic ultrasound and nuclear imaging.

Further information may be obtained from Eman-

uel Salzman, M.D., Conference Chairman, Division of Radiology, Beth Israel Hospital, Denver, CO 80204. (303) 825-2190.

Clinical Hematology Is Conference Theme

The American College of Physicians (ACP) will sponsor a three-day postgraduate course in clinical hematology Mar. 7-9, 1977, in Birmingham, AL. The course will be co-sponsored by the University of Alabama School of Medicine.

The American College of Physicians postgraduate courses have been approved by the American Medical Association Advisory Committee on Continuing Medical Education and this course may be used to fulfill 19¼ hours of Category 1 requirements for the AMA's Physician's Recognition Award.

The Birmingham course entitled, "Solving Problems in Clinical Hematology," is being planned by co-directors Thomas W. Sheey, M.D., and Marcel E. Conrad, M.D. Both are professors of medicine, division of hematology/oncology at the University of Alabama School of Medicine.

For information and registration write Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, PA 19104.

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the real
thing



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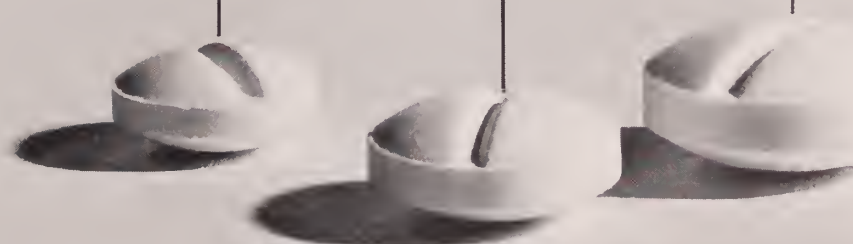
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■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.

■ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

***INDICATIONS.** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 18-23, San Francisco. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

La.-Miss. O. and O. Society, Mar. 10-13, 1977, Biloxi. Arthur Hays, M.D., Secy., 3017 13th St., Gulfport 39501; Ben Davis, Executive Secy., P.O. Box 12314, Jackson 39211.

Tri-state (MS, LA, ARK) Heart Associations Scientific Session, "Perspectives in Cardiology," May 18-20, 1977, Broadwater Beach Hotel, Biloxi, MS. Bill Dawkins, Program Director, P.O. Box 16063, Jackson, MS 39206.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 6-9 1977, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 109th Annual Session, May 2-5, 1977, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Henry McCrory, Secy., P.O. Box 340, Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. G. L. Arrington, Jr., Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1167, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Thomas Glasgow, Secy., 1196 Mound St., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. James H. Sams, Secy., 321 Hospital Drive, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

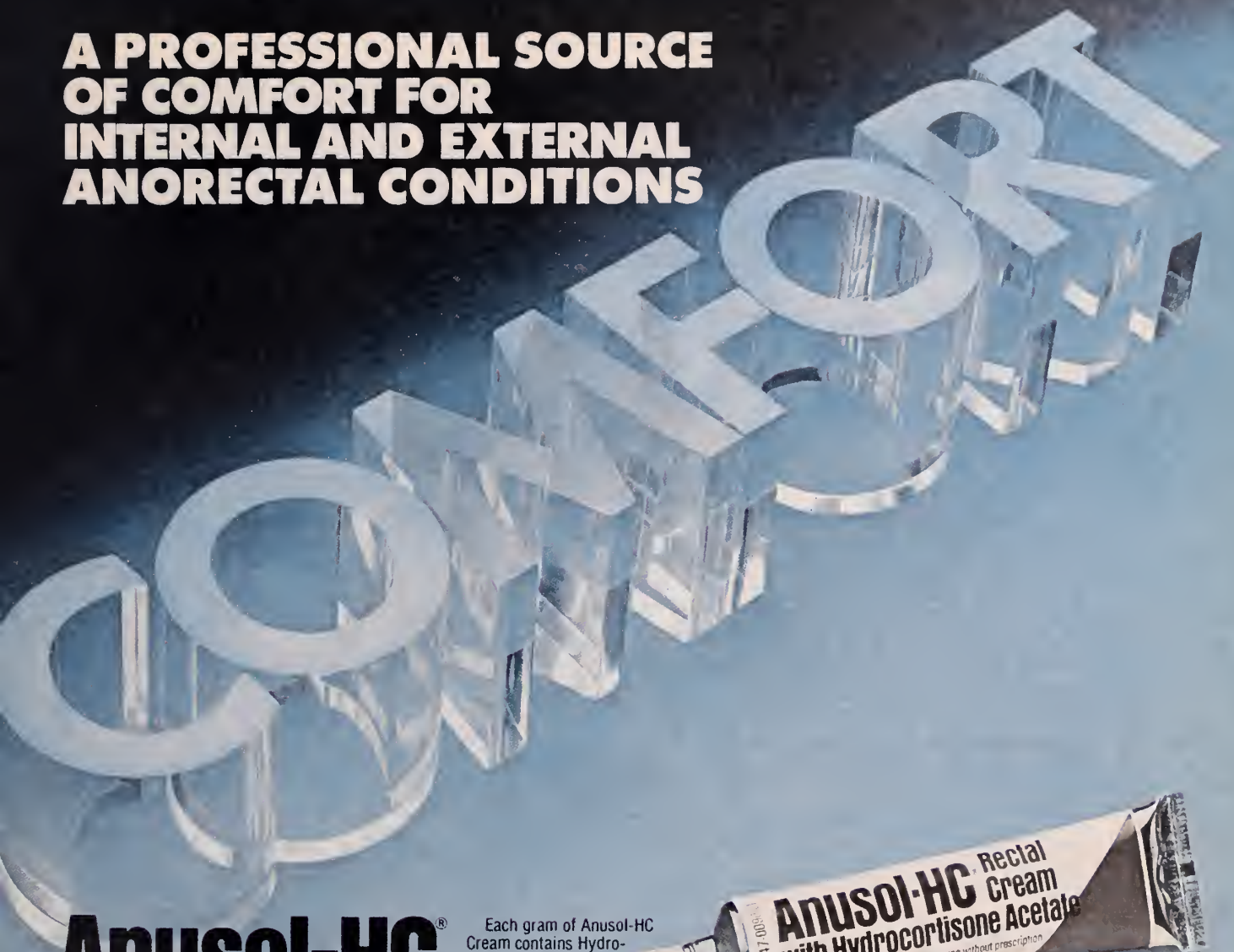
Singing River Medical Society, 3rd Monday, February, May, August, November. Clyde Gunn, Jr., Secy., P.O. Drawer G, Moss Point 39563. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Thomas Blake, Secy., 424 S. 13th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

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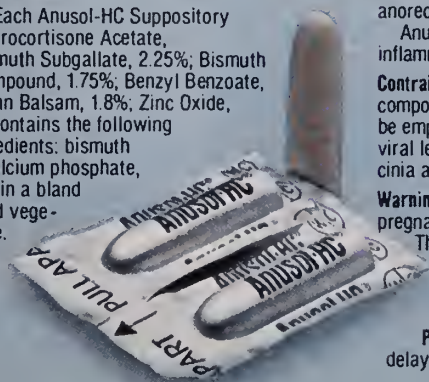
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CAUTION: Federal law prohibits dispensing without prescription.

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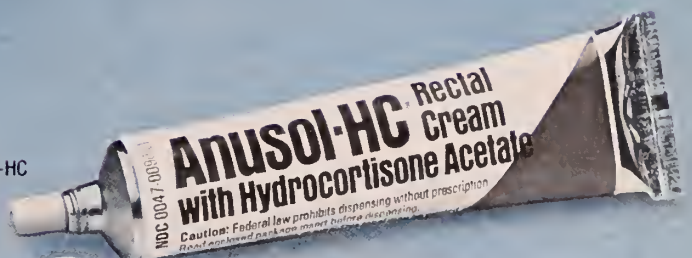
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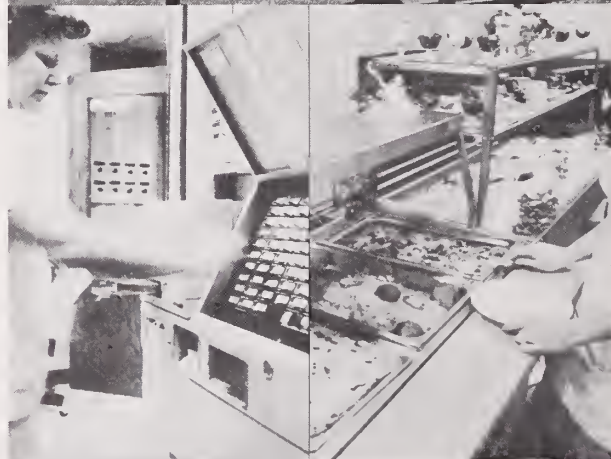
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ORIGINAL PAPERS

Emergency Eye Care

D. R. CALDWELL, M.D.

Jackson, Mississippi

ALTHOUGH VAST amounts of material on ocular emergencies can be found in ophthalmic literature, very little has been written for the physician, other than the ophthalmologist, concerning the common problems encountered in the routine emergency eye case. This paper intends to present for the physician a practical and concise review of the diagnosis and treatment of the emergency eye problems most frequently encountered.

I. CHEMICAL INJURIES

There are two ocular emergencies which must be treated within a matter of minutes, if not seconds, if vision is to be preserved: chemical injuries and central retinal artery occlusions (Section II).

The use of industrial, agricultural, and home chemicals has increased markedly in the past few years and a corresponding increase in ocular chemical injuries has resulted. The extent of permanent injury is directly related to the nature of the chemical, concentration of the chemical, and the time lapse before complete removal of the chemical from the eye. Treatment of all chemical injuries begins with immediate removal of all foreign material by copious irrigation with water from the first available source. One must make certain that the eyelids are opened wide; this may be very difficult because the natural tendency is for the patient to squeeze the lids closed. Anesthetic drops may be used to relieve pain and allow better eversion of the lids. The lids should

be single or double everted and all material irrigated or wiped from the conjunctival and corneal surfaces with cotton applicators. An alternate method of immediate irrigation is to have the patient submerge his face in water and open his eyes beneath the surface. Of the various types of chemical injuries, alkalis have by far the most deleterious effect and, if the in-

The author presents information on common problems encountered in the routine emergency eye case. He gives a practical and concise review of the diagnosis and treatment of chemical injuries, central retinal artery occlusions, lacerations, blunt traumas, foreign bodies, corneal abrasions, overwearing of contact lenses, red eyes, and retinal detachments.

jured eye is not copiously irrigated within seconds, vision may be completely lost. Irrigation should be continued for at least 30 minutes for acid-type injuries and much longer—usually 12 hours or more—for alkali burns since they continue to worsen for many hours. Neutralizing solutions are generally to be discouraged since the thermal reaction may increase the severity of the injury. A bottle of normal saline with an IV tube makes an excellent source of fluid. Collagenase inhibitors, such as acetylcysteine, help prevent perforations from severe alkali burns and should be administered as soon as possible.¹

Due to the seriousness of chemical injuries and the resulting complications—corneal opacification

From the University of Mississippi Medical Center, Jackson, MS.

and ulceration, conjunctival and scleral scarring, cataracts, and glaucoma—patients with these injuries should be seen as soon as possible by an ophthalmologist. The ophthalmologist would, in these instances, dilate the pupil and administer topical antibiotics and, in the case of severe burns, steroids.

II. CENTRAL RETINAL ARTERY OCCLUSIONS

Occlusion of the central retinal artery results in sudden, painless loss of vision. The major causes are vasospasm, atheroma formation and emboli. Branch artery occlusions can occur and are nearly always due to emboli, particularly those arising from mitral valve or carotid disease. Embolic obstruction causes a sudden, complete loss of vision without premonitory symptoms, whereas vasospastic disease is frequently preceded by transient episodes of blindness (amaurosis fugax). Direct ophthalmoscopy of the retinal arteries shows segmented blood flow, constricted arterioles, marked edema of the inner layers of the retina with a cherry red spot in the macula. The red spot is simply the normal foveal color since the inner layers of the retina are absent in the fovea. The prognosis is related to the cause, degree of obstruction, and the length of time the occlusion has been present. If circulation can be restored within the first hour, there is a fair chance for the return of all vision; if restored within two to four hours, peripheral vision may be saved, but central vision lost. After four to six hours, it is unlikely that any vision will return, but an attempt should be made to restore circulation because there may be undetected minimal circulation, possibly enough to prevent permanent death of the retinal cells.

Treatment is directed toward relief of the vasospasm and/or an attempt to move the emboli to a more peripheral arteriole. Digital massage of the globe will sometimes open a previously closed artery, and should be carried out immediately after diagnosis. A moderate amount of pressure is applied to the globe for three to five seconds and then suddenly released. After five to 10 seconds, the pressure is again applied. This pressure and sudden release should be repeated several times. While the massage is being carried out, the patient should be given a 5-10 per cent CO₂, 90-95 per cent O₂ to breathe or, if unavailable, one can use the old "brown paper bag" routine. Nitroglycerin can be administered sublingually. Intravenous mannitol or acetazolamide (Dia-

mox® 500 mgm.) should be given to lower the intraocular tension and IV heparin should be considered. An ophthalmologist may want to do a paracentesis of the anterior chamber to decompress the globe. A retrobulbar injection of hyaluronidase (Wydase® 150 n. r.) in an attempt to decrease intraocular pressure by disseminating orbital edema, and retrobulbar aminophylline (25 mgm. in one ml. diluent) for vasodilation can be administered. The hyaluronidase and aminophylline can be mixed and only one retrobulbar injection given. A stellate ganglion block with anesthetic agents may also be of value in producing vasodilation.

Since giant cell arteritis (temporal arteritis) may cause occlusion of the central retinal artery and sudden loss of vision, it should be mentioned here.² The typical patient with temporal arteritis is over 60 years of age and has a history of fever, headaches, and general malaise. Pain noted while chewing is a common complaint, the temporal arteries are tender to the touch with nodularity sometimes palpable, and palsies of the extraocular muscles sometimes occur. Usually it is a week or more before visual symptoms develop but sudden loss of vision due to central artery occlusion can occur. Frequently, the second eye becomes involved shortly after the first, making it imperative that the diagnosis be made early. The sedimentation rate is always elevated in the active disease and the serum alkaline phosphatase may be elevated. All cases of unexplained sudden visual loss in patients over 40 should have a stat sedimentation rate and, if elevated, temporal artery biopsies. This devastating loss of vision is usually permanent; however, this disease responds, sometimes dramatically, to systemic corticosteroids and frequently the second eye can be saved although the corticosteroids will frequently need to be used over extended periods of time. Initial high doses in the range of 100-120 mgm. Prednisone will be required and the vision and circulation monitored closely as the dosage is slowly tapered off over a period of several weeks. Normal precautionary measures associated with the use of systemic steroids need to be followed.

III. LACERATIONS

Penetrating injuries of the globe require immediate diagnosis. In most cases the injury is readily apparent but in some cases it can be very difficult to discover. The iris, ciliary body, or other uveal tissue may be prolapsing through the wound and the anterior chamber may be flat, very shallow, or filled with blood either totally or partially. The depth of the anterior chamber can be determined easily with

a pen light by shining the light from the side, across the iris. If the iris is in the normal position (3 mm. behind the posterior surface of the cornea) and flat, the total iris will be illuminated. If the iris is convex, the portion of the iris closest to the light will be illuminated and the portion farthest from the light will reflect little light and appear darker. The anterior chamber depth will probably be less than 2 mm. if the cornea is perforated. The intraocular tension will be near zero; however, the pressure should be taken only with great care when a perforation is suspected. If the pressure is normal, a perforation is not present or has been sealed with the foreign body, blood, fibrin, or intraocular contents.

Treatment of the eyes with corneal or scleral lacerations must be approached with two major points in mind. First, the eye must be protected at all cost from external pressure for the ruptured globe is somewhat like a grape with a ruptured skin—the slightest pressure and the pulp comes farther out. This protection can best be achieved by placing an eye pad on the injured eye and over it securing a metal shield resting on the bony orbit. An eye pad should also be placed over the uninjured eye in order to discourage all eye movement. If at all possible, the patient should rest quietly, flat on his back and not be allowed to turn. In all cases of ruptured globes, x-rays should be taken to determine if foreign bodies are present. Blepharospasm should be relieved with sedation, topical anesthetic drops, and/or, in some severe cases, a facial nerve block. Second, the eye must be protected from infection by the use of systemic antibiotics and topical antibiotic drops—ointment should never be used in an open globe. Prophylactic antibiotics have proven to be effective in perforations of the globe and are an essential part of the treatment. Intraocular infections are usually totally disastrous to vision and can be prevented in most cases. NeoSporin® or gentamycin ophthalmic drops are usually present in most emergency rooms and doctors' offices and should be used hourly until surgery. A combination of intravenous gentamycin (60 mgm.) and methicillin (1 gm.) every six hours will give both broad spectrum coverage and good ocular penetrancy. Tetanus immunization should be considered as in any other type of laceration. These procedures should be carried out while the patient is being prepared for surgery under general anesthesia. Certainly, the anesthetist will need to be made aware of the problems of extrusion or expulsion of the intraocular contents if a gentle induction is not carried out.³

IV. BLUNT TRAUMA

Frequently, blunt trauma to the eye will not produce a rupture of the globe but will produce tears at the iris root (iridodialysis), choroid rupture, and retinal tears which can produce intraocular hemorrhage. If the hemorrhage is limited to the anterior chamber, it is referred to as a hyphema. BB's, pellets, spit balls, and other small round projectiles can cause hyphemas. The hyphema is easily diagnosed with a pen light—a blood level may be observed in the case of a partial hyphema or the entire anterior chamber may be filled with blood in a total hyphema. The patient should be hospitalized and confined to bed with both eyes patched since bleeding frequently recurs within five days following injury with even the slightest exertion. Sedation and strong mydriatics such as Atropine 1 per cent drops can also be used to keep the patient, iris, and ciliary body at rest. Hyphemas are fraught with complications and vision is often lost due to these complications; consequently, in all cases they should be evaluated by an ophthalmologist as soon as feasible.⁴

V. FOREIGN BODIES

The most common eye emergency is the foreign body. Presence of foreign material in the eye can usually be determined with a pen light. Irrigation of the eye with Blinix® or other irrigating solution will sometimes remove foreign bodies which are not imbedded. The examiner should grasp the skin of the upper lid, pull the lid away from the globe and direct a small stream of irrigating solution under the upper lid and similarly treat the lower lid. The foreign body may be flushed from the eye and if anesthetic drops are not used, the patient will be able to tell whether or not the offender is gone. Frequently, however, the foreign body will have become partially imbedded under the upper lid making it necessary to evert the lid for removal. Everting the lid is easily done by grasping the central lashes, raising the lid away from the globe, and applying pressure at the lid fold with a cotton applicator while the patient is looking downward. A moist cotton applicator should be used to remove the foreign body from the conjunctiva but if this method proves unsuccessful, an 18 gauge needle can be used to dislodge the foreign body. Corneal foreign bodies that cannot be removed by irrigating the eye should be lifted off the cornea with a needle or foreign body spud, after application of topical anesthetic, since a cotton applicator might push them deeper into the cornea penetrating Bowman's membrane and scarring the cor-

nea. If the foreign body contains iron and has been in contact with the cornea for a few hours, a rust ring will surround the foreign body and it should be removed at the time the metal is removed. It can be removed later without any additional injury to the cornea. There are several battery powered dental burs commercially available which are supposed to remove the rust ring and necrotic cells without damaging normal tissue, however, the more powerful units are capable of penetrating the anterior chamber if enough pressure is applied and I have seen such a case. The very low-powered ones—and, also, the least expensive—will stop rotating before enough pressure can be applied to penetrate Descemet's membrane. After the foreign body has been removed, broad spectrum antibiotic drops should be instilled in the eye. If the foreign body was corneal, the eye should be tightly patched for at least 12 hours to allow the epithelium to regenerate and then the eye reexamined for signs of corneal ulceration (Section VIII).

VI. CORNEAL ABRASIONS

The second most common emergency eye case is the corneal abrasion. No matter how small the corneal abrasion, the patient will have a foreign body sensation, blepharospasm, tearing, and sometimes severe pain with blinking or movement of the eye. An abrasion can be easily diagnosed by touching the conjunctiva of the lower lid with a sterile strip of fluorescein paper moistened with irrigating solution. The aqueous solutions of fluorescein are notorious for becoming contaminated with pseudomonas and therefore should never be used. The denuded area of the cornea can then be seen by using a pen light with a cobalt blue filter. Sometimes when the pen light is used without fluorescein, the epithelial defect will produce a shadow on the iris. Following diagnosis, broad spectrum antibiotic drops should be instilled as well as a moderate acting mydriatic (Homatropine 5 per cent) and a pressure patch applied. Atropine drops or ointment should not be used since the epithelium will usually regenerate long before the effect of the Atropine wears off which may be several days. A mild pain medication can be administered and ice packs applied to increase patient comfort. The abrasion will usually heal within 24 to 48 hours, but should be followed daily until completely healed and all staining with fluorescein has disappeared because, occasionally, the abrasion will become infected and a corneal ulcer will develop.

The contact lens wearer suffering from pain, photophobia, excessive tearing, foreign body sensation and severe blepharospasm will occasionally seek emergency care. The patient will usually have a history of overwearing (the overwearing syndrome). Examination will reveal edema of the lids, edema of the epithelium in the central portion of the cornea, and usually central staining with fluorescein dye. Treatment consists of a short-acting cycloplegic to relieve ciliary spasm, bilateral pressure patches, and possibly an analgesic if the pain is severe. An ice pack will also provide relief. The symptoms will last from 12 to 24 hours and the patient should be examined by an ophthalmologist before wearing the lenses again.

VIII. RED EYES

"Red eyes" are frequently seen in emergency eye cases. The possible diagnoses are several including conjunctivitis of all types, angle closure glaucoma, iritis, intraocular inflammations, corneal trauma (discussed in Section IV), corneal ulcers, and orbital cellulitis. It is essential that the proper diagnosis be made. The patient's vision (with any correction he might have) is the most important single entity to be checked. If the vision is significantly reduced, the patient should be evaluated by an ophthalmologist. Vision is usually normal in conjunctivitis, moderately decreased in iritis, and markedly decreased in acute glaucoma and corneal ulcers.

Acute conjunctivitis is extremely common and is usually viral or bacterial. Of these, only gonococcal conjunctivitis is a true emergency and appropriate treatment must be carried out at once or the patient will develop corneal ulceration and possibly perforation within hours. Any ocular discharge should be smeared, a Giemsa stain made to determine cell type and a gram stain made to determine organism types if present. Generally, bacterial infections will produce a polymorphonuclear response and the organisms can readily be seen on the slide. Appropriate antibiotic treatment in the form of drops or ointment as well as cleansing and warm compresses is indicated. If no improvement is observed within 24 hours, the patient should be examined by an ophthalmologist since secondary corneal involvement or spreading to adjacent ocular tissue may occur. Viral conjunctivitis is characterized by minimal discharge, prevalent tearing, conjunctival smears exhibiting mainly a mononuclear response or, if secondary bac-

terial infection is present, a mixed cellular response, and inclusion bodies in the epithelial cells. Viral infections are self-limiting; however, the disease state can linger on for several months or even years. Protection from secondary bacterial infections should be considered and broad spectrum antibiotics used. Allergic conjunctivitis definitely can occur but, in my experience, is grossly over-diagnosed and usually iatrogenic in origin. The conjunctival smear will show eosinophils in various stages of development. Corticosteroids have a very limited place, if any, in the treatment of the usual conjunctivitis since these drugs predispose patients to secondary infection of all types, precipitate glaucoma in some individuals and cause cataracts. If steroids are used, the poor ocular penetrating drugs such as medrysone (HMS®) or fluorometholone (FML®) should be administered.

The classical case of acute angle closure glaucoma is easily diagnosed. The patient experiences tremendous pain in or around the orbit, nausea, vomiting, headaches, markedly decreased vision, a stony-hard eye with marked congestion of the conjunctival vessels, and a steamy, cloudy cornea due to the edema. The milder and sub-acute types frequently go undiagnosed for several hours and a profound loss of vision occurs. Every patient over 40 with a non-specific nausea or vomiting should be questioned about eye symptoms (pain, halos, etc.) and the intraocular pressure checked even if it can only be done tactilely. Tactile tensions, even though very gross, can indicate whether the pressures are greatly elevated. The diagnosis is confirmed by a markedly elevated intraocular tension and a shallow or flat anterior chamber. Angle closure glaucoma is a surgical disease but surgery is best done after the acute blockage is eliminated. Medical management is a difficult problem but the sooner treatment is started, the greater the success. Intravenous Mannitol should be started immediately and strong topical miotics such as Pilocarpine 4 per cent every hour should be instilled. As soon as the pressure is relieved, surgery should be performed to prevent further recurrence.

Corneal ulcerations can occur from numerous etiological agents—bacteria, virus, fungi, etc. The diagnosis is easily made even in the early stages by examination of the cornea with a pen light. Inflammations produce a varying degree of cellular infiltrates causing a loss of the normal corneal luster and transparency to frank opacification for a portion of, or the total, cornea. Since ulcerations, even if treated promptly and correctly, frequently result in loss

of vision, perforation, and endophthalmitis, they should be referred immediately to an ophthalmologist.

The condition of orbital cellulitis, prevalent in young children, is characterized by proptosis lid edema, chemosis, ocular pain, limited motility, redness and increased temperature of the orbit. Paranasal sinuses are frequently the source of the infection in children, whereas mucormycosis is frequently the cause in debilitated patients. The entity generally responds to parenteral antibiotics which must be given in sufficient doses to completely clear the sinus. Any surgery should be approached with extreme caution since a spreading of the infection usually results; however, surgery sometimes is necessary. Cultures from any possible source or discharge, as well as blood cultures, should be taken prior to instituting broad spectrum antibiotics in maximum doses. If unsuccessfully treated, complications of cavernous sinus thrombosis, meningitis, endophthalmitis, and optic atrophy can result in loss of vision or life.

IX. RETINAL DETACHMENTS

Patients with a retinal detachment will present with the classical symptoms of "lightening flashes," showers of dark spots, and a progressive visual field loss described by the patient as a "veil" or "curtain" coming over the eye. Any patient with these symptoms should be seen immediately by an ophthalmologist since breaks or tears in the periphery of the retina can best be observed by indirect ophthalmoscopy. Undulating vessels are seen crossing folds of retina which have taken on a grayish-white, opaque appearance. Once the diagnosis of a retinal detachment is made, immediate surgery is indicated.

SUMMARY

The more common emergency eye problems have been briefly presented and discussed in this paper. Numerous other conditions will occur; however, they have either been discussed more comprehensively elsewhere or rarely occur. ★★★

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Vibrometry and Neuropathy

CARLTON R. DANIEL, III, JOHN D. BOWER, M.D.,
JAMES E. PEARSON, M.S., AND
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Jackson, Mississippi

VIBRATORY SENSE is poorly understood. The inference that it is a separate "modality" has been proposed only with certain reservations. Attempts to clearly define or describe vibratory sense have failed, chiefly, because of uncertainty and ambiguity concerning the transduction of tactile energy and pathways to the central nervous system. Calne and Pallis,¹ after critically reviewing the literature, described vibration as representing temporal modulation of tactile sense analogous to the relationship between flicker and vision.

According to Tate,² the pacinian corpuscle is responsible for transduction of vibratory energy. Calne and Pallis further substantiate this finding.¹ This receptor appears in fascial planes, around joints, nerve trunks, adventitia of blood vessels, base of nipples, pancreas, and the external genitalia. The corpuscle reacts to the frequency range (90-600 cycles per second) which corresponds to the vibratory spectrum perceived by man. From these receptors, long afferent fibers are thought to course through the lateral and dorsal columns up to the sensory cortex.¹ Therefore, vibratory threshold is often used as an accurate index of peripheral neuropathy.

In reviewing the literature, we also found a high correlation for vibratory sensations with uremia. Working with dialysis patients and normals also added to our practical knowledge about the application of vibrometry. Interestingly, impairment of vibratory sensation was found to be one of the earliest and most frequent clinical signs of peripheral nerve dysfunction in uremia.³ This is consistent with the fact that in uremia the sensory modality malfunctions well before the motor neurons.³ The pathophysiology of this neuropathy is unknown; however, histologic studies of the peripheral nerve trunks have shown destruction of myelin and axon cylinders, predominantly in the distal segments.⁴ Once established, a peripheral demyelinating neuropathy, most marked in the legs, often can not be ameliorated.

Progress can be made though by intensive hemodialysis. This has been accepted to the extent that impairment of vibratory sense and nerve conduction is frequently used as a pathognomonic sign to initiate dialysis.³⁻⁵ In addition, successful renal transplantation may remedy the problem.⁶

Vibratory sensation is poorly understood, but it has been used for years via tuning forks and other instruments by general practitioners, internists, neurologists, and nephrologists to give a gross estimation of diabetes, uremia, and vitamin deficiency diseases and other forms of neuropathy. Recently, through our experience with dialysis patients, normals, and a review of literature, we have found standardized vibrometers to be useful in giving quantitative information concerning neuropathy. By utilizing baseline data and certain general principles concerning vibratory sense, a vibrometer is a simple diagnostic tool for the primary physician to use in following common neuropathy.

The progression of uremic neuropathy has been followed by cutaneous thermal discrimination, touch-pressure instruments,⁷ and tuning forks. Some of these techniques are frequently less than adequate, especially the non-quantitative tuning fork.⁸ Notwithstanding, calibrated vibrometers and peripheral nerve conduction measurements have recently been used to test normals and patients with renal failure. The latter diagnostic method is costly and time consuming. Nevertheless, its readings have often been used to help define an adequate hemodialysis; adequate being one which prevents the further development of peripheral neuropathy.⁴ Contemporary reports^{5, 9} are available, presenting evidence that the vibrometer may well replace the complicated peripheral nerve conduction readings as a monitor of peripheral neuropathy as well as a gauge of the efficacy of hemodialysis.

From the University of Mississippi Medical Center, Artificial Kidney Unit, Jackson, MS.

Daniel et al¹⁰ recently explored two populations: one of normals and one of dialysis patients. In that study, the following observations were made and supported by testing the distal condyle of each ulna and each lateral malleolus of the fibula.

- I. Normal group
 - A. The dominant arm had a statistically significant higher threshold than the non-dominant arm ($P < .01$).
- II. Dialysis group
 - A. As the age of the patient increased, his threshold values increased ($P < .01$).
 - B. The longer the patient had been on adequate dialysis, the lower his threshold values ($P < .01$).
 - C. The vibrometer is a useful supplement and alternative to nerve conduction techniques in following peripheral neuropathy in general as well as efficacy of hemodialysis.^{10, 11}

The vibrometer used was a Bio-Thesiometer (Chagrin Falls, Ohio). The amplitude was graded in vibratory units and calibrated in microns of motion read from a dial. Calibration began at zero or lowest threshold and ascended to 50 units, which was the maximum reading. It was electro-magnetically powered with a frequency lever of 120 Hz. The stimulus strength was expressed as the square of the voltage of electrical energy supply to the vibrometer according to the equation: $A = K (V^2/M)$ (A = Amplitude of vibration; M —Mass; V —Volts). Vibration was transmitted to the test area via a tactor (an applicator) with a slightly rounded surface, 13 mm in diameter.⁸

From this work with normals and dialysis patients and after reviewing the literature, we have made the following general conclusions:

We feel that a vibrometer is a valuable adjunct to the physician's diagnostic armamentarium. It is a simple procedure that may be performed by technical personnel with only a minimal amount of time involved. (See Table I.) General practitioners, internists, neurologists, and nephrologists frequently employ vibratory sensation in general physical examinations, simple hearing tests (Weber and Rinne Tests) as an aid for screening for vitamin B-12 deficiency, peripheral neuropathy of diabetes, or uremic peripheral neuropathy. Most of the time subjective, non-quantitative data from tuning forks or other non-quantitative instruments are used. We feel that this information is often less than adequate.

Baseline data, given with accompanying literature by various calibrated vibratory instruments along with initial and progressive readings from individual patients, give the physician a foundation to interpret his data base. This can be extrapolated, quantitatively, according to the specific entity being followed as with common, diabetic peripheral neuropathy.

Furthermore, one must keep in mind the age factor and the fact that the dominant limb frequently has a higher threshold than the non-dominant limb. Therefore, we again emphasize that individual baseline data is most important.

We have observed that calibrated, standardized vibrometry is an important aid to the physician. By relating our experience, we hope that other practitioners will recognize the instrument's utility. But we

TABLE I
COMPARISON OF VARIOUS INDICATORS OF PERIPHERAL NERVE FUNCTION

<i>Instrument</i>	<i>Unit Price</i>	<i>Patient Cost</i>	<i>Recorder's Preparation and Examining Time</i>	<i>Patient Preparation/Discomfort</i>	<i>Training Needed</i>	<i>Accuracy</i>
Vibrometer	*\$165.00	Physician's discretion	3-10 minutes (minimal)	Remove clothing from testing area/none	Minimal tech. nurse, etc.	Quantitative in absolute units
Motor nerve conduction velocity	Too much for individual use	\$15.00 to \$50.00	45 minutes to 2 hours	15 minutes/some discomfort	Extensive	Quantitative
Tuning fork	Minimal	Physician's discretion	Minimal	Remove clothing from testing area/none	For interpretation of test	Subjective

All values are approximate.

* Based on Bio-Thesiometer (Chagrin Falls, Ohio).

will leave it to the neurologists to adequately explain its mechanism and to expound on the various technical aspects of the procedure. ★★★

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Sometimes give your services for nothing,
Calling to mind a previous benefaction or
Present satisfaction. And if there be an
Opportunity of serving one who is a
Stranger in financial straits, give full
Assistance to all such. For where there
Is love of man, there is also love of the art.
—Hippocrates

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COMFORTABLE HEARING

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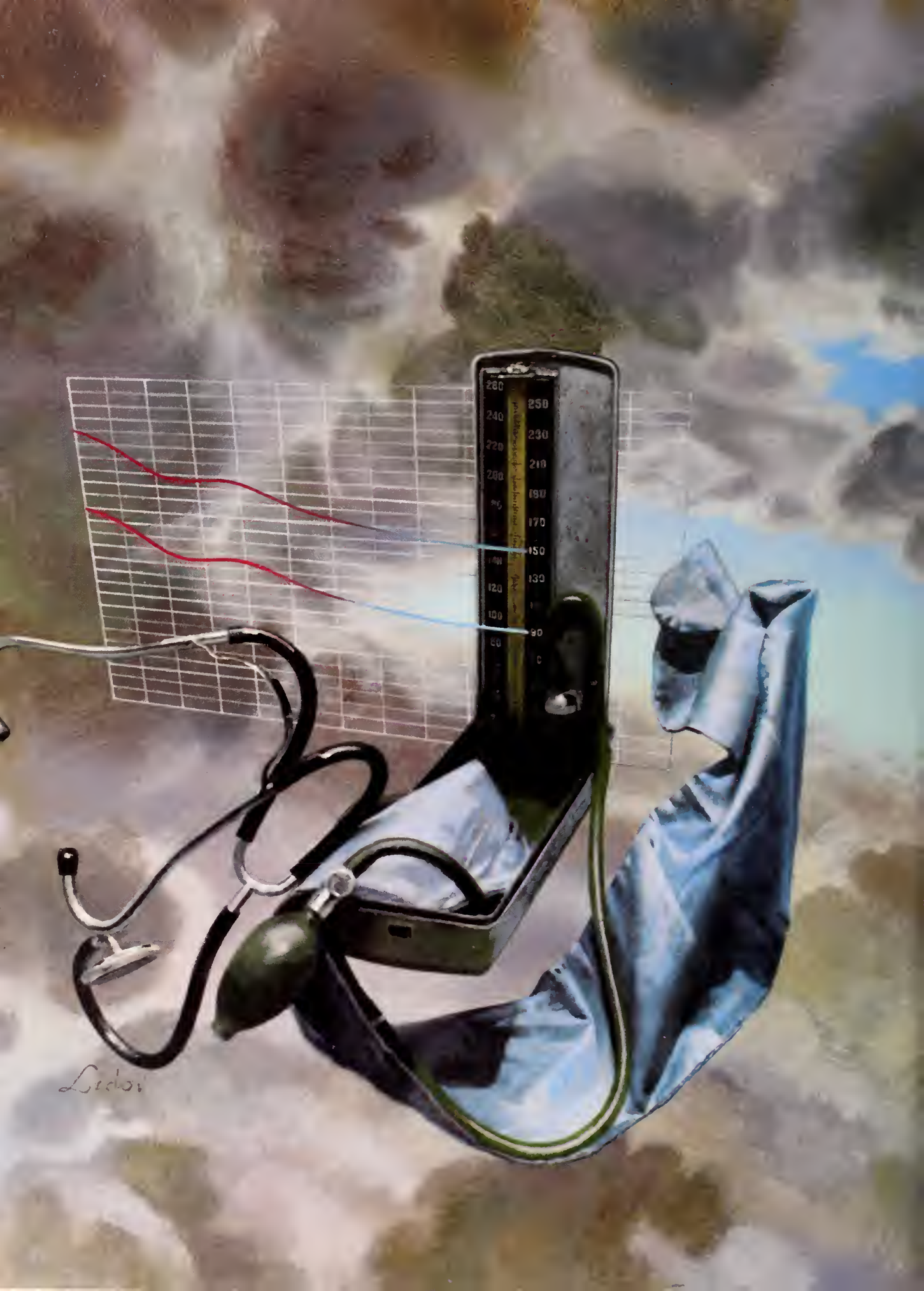
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Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma; allergy or sensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing

age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth,

hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg, edema of cardiac failure—5 to 10 mg, edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg

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This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with

cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy. Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium[®] (triamterene, SK&F Co.), and

leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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Assuring Continuing Professional Competence*

BERNARD J. PISANI, M.D.

New York, New York

WHEN WE SPEAK about relicensure and recertification, we are really addressing ourselves to the continuing competency of the individual. Competency cannot be judged only in terms of dexterity and technique. The commitment of the physician involves much more in terms of reliability, conscientiousness, and ethical and moral values.

Competency has a diverse nature like Joseph's "coat of many colors." Character is the most important ingredient and should be looked at closely before acceptance to medical school and during education. Straight "A" students are not necessarily the best practitioners of medicine. Overachievement in academic studies, or academe as it is now called, sometimes is an indication of poor social relationship, which is not the attribute most desired in the treatment of patients. The nature of the student is far more important.

Performance, in all its aspects, is the primary rule of competency, and no state or federal review will change it. It should not be questioned or examined by people outside the profession. Medical societies can and should play a much more active role in the supervision, censure, even recommendation of the delicensing of a physician. In the matter of continuing competency, it is imperative that local, county, state and the AMA become much more involved than they have been. If we don't discipline our own profession, authority will go to the legal profession or to federal control.

Doctors long ago formed their closed society, which didn't come under question until recently. Now we are blamed for everything: hospital costs which are not within our province; rising insurance costs which are taking their toll in the form of early retirement; job actions and outright strikes by doctors. Until now, doctors have not been very political. But now, because the cost of practice has risen

so drastically and abruptly, the doctor is far more aware and concerned with the legal and political aspects of the practice of medicine.

In a discussion on continuing competency, relicensure and recertification, I would like to quote a brief paragraph that was in the "op-ed" page of the *New York Times* of Thursday, January 15. It was written by Neil Chayet, who is considered a specialist in medical-legal matters. He wrote of "a fatally flawed system by which we compensate injury and death. That system, as it affects victims of medical malpractice, causes insurance companies to rake in \$1 billion in premiums but returns only \$250 million to patients. The rest goes into the companies' profits, to the bureaucracies that handle claims and to the lawyers." Mr. Chayet is a lawyer.

Members of the legal profession do not have to take competency or recertification examinations. Ours is a profession apart, but very much involved with the legal profession.

There is a difference between incompetence and malpractice. Who is to judge, doctors or lawyers? Much as we are insulted by the cost of malpractice insurance, we must be reasonable enough to acknowledge that malpractice does exist, and the monetary element cannot be ignored. The point is who makes the decision.

William O. Douglas resigned from the Supreme Court of the United States because he recognized his inability to perform at the high quality expected of him. Many doctors, not having his wisdom, continue to practice when they should not. There should be an acceptable and courteous way to limit, or ultimately curtail, hospital and private practice by doctors who have become recognized as incompetent. The performance of an act of this kind is very difficult and medical associations have not provided guidelines of procedure.

We have right now a case in New Jersey that is full of medical and political consequence. It will be adjudicated by lawyers and the verdict decided by laymen.

The medical profession must oversee and discipline its members far more than it has. Our rules

Presented at the annual meeting of the Federation of State Medical Boards, Chicago, Jan. 31, 1976.

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and laws should be clarified for just such purpose. It is much too complicated to have anyone reprimanded, much less barred from practice. Peer review is one tool that can and should be used, but a PSRO judgment would have to be adjudicated, which would be a lengthy and costly procedure. The medical profession has not faced this problem openly until now. It is a difficult one and answers don't come easily.

Once licensed, the doctor is in a relatively free, uninspected, unsupervised position. Unless criminal action is involved, there is at present almost no policy within the medical profession to investigate possible, even probable, incompetency. Should we come right out and admit we don't investigate malpractice? We have let the legal profession take over and left our own house in disorder, and the cost to all of us is horrendous.

Insurance (and/or assurance) of continuing competency within the many specialties (and now subspecialties) would demand an elitism of professional judgment which would be hard to verify or assess. Members of the various boards and colleges are not always in the best position to make such judgments. Educational mastery of science or art is not a true or complete estimate of actual performance. Human contact and empathy play a large part in medical treatment and that is not learned within the pages of textbooks. It *is* contained in the on-growing character and personality of the individual.

In medicine, the rapport between patient and doctor is very important, and we have been letting go of this. The varieties of specialization are largely at fault.

I think fondly of a friend and surgeon who died many years ago. When he was still practicing in his fifties and more, I was taking board examinations. I was relatively young and ambitious; he was well trained and experienced. Board certification was the new thing to do—it got your name in the proper registries, you were referred more patients, but basically it had more to do with the price you charged the patient. I will always remember his shaking his head at the idea and telling me he was too long out of school to take examinations. His performance was far more important than any examination.

Book and lecture education is something quite apart from the personal treatment of patients. Often the person who wrote the book or gave the lecture has rarely taken care of a patient. Continuing education has far more to do with the day-to-day—in my case, it was more often night-to-night—personal contact.

Discussion and demonstration are important factors in ongoing education within the hospital. Quality of care outside the hospital is difficult to assess. This is one reason why the character and personality of the applicant to medical school should be much more closely considered than the ability to obtain outstanding grades. The good doctor is truly concerned with the patient.

This brings up the subject of the FMG's whom we have allowed to multiply for our own various reasons, which I will not go into. The U. S.-trained physician is not necessarily always superior or has higher standards, but we are living in a time when moral standards are changing. Pragmatic and monetary gain has become more important, and it is increasingly difficult to evaluate the ability of a doctor. The language barrier makes it even more difficult and is extremely hard on the patient—of course, that works both ways.

In the wake of World War II, the many accomplishments in medicine, both preventive and therapeutic, led to the growth of specialization and then to subspecialization. The practice grew and multiplied. Guidelines became important and so did board certification. The legality and administration of health care became entangled with socioeconomic and legal interests and pressures. Rules and regulations proliferated.

The more refined the discipline, the specialization, and the subspecialization became, the more restricted was the physician, and the medical profession was left with fewer persons providing broad, comprehensive service, or what we call "primary care." The overall needs at a lesser expense for the majority of people became lost in the jungle of expertise.

The effort to achieve higher selective competency and board certification was largely a part of seeking higher compensation and often shorter work hours.

In our effort to improve on the intricacies of medical science, we have upset the balance of general care, and as a result, we are a threat to our own survival.

Doctor John Hubbard wrote, "Yet another reason for a good hard look at today's disjointed system of evaluation is the prodigious amount of overlap and outright duplication in the efforts and time of those who are called on to serve on examination committees and create questions in closely related fields."

The question of on-going competency has been with us a long time and it will persist. Within our circumscribed profession, we have not established a method or means other than voluntary reeduca-

tion, and this can be questioned as to its efficacy.

Computer-based and record audit examinations are unworthy and often in error. In Chicago, you must have heard news of the motel owner who sent out thousands of letters thanking people who had stayed there. Unfortunately, the computer sent out a different file of names and addresses. It caused quite a few upsets between couples when a wife thought her husband had been on a business trip or attending a congress like this!

The suggestion of the gradual development of an orderly system for evaluation of professional competence as a means of achieving public accountability reminds me of the song in "The Man of La Mancha"—"The Impossible Dream."

There is a story told of a man buying a car who requested that one side be painted red and the other side blue. "Why?" asked the car dealer. "Can't you see the fun if I ever get into an accident and the on-lookers are asked to describe the car?" replied the buyer. So much depends on how we look at things and from what side we see them. We don't have to look beyond the end of our nose to find a thousand and one things to complain about as we look back on these past years, and yet, by comparison with medical education and practice in other parts of this world, we do have so much to be thankful for and grateful for—a myriad of resources and advances.

"Medicine's Conscience for More Than Two Decades" appears on pages 26 and 27 of the January 1976 *Federation Bulletin*, and I would like to quote this statement from Dr. Casterline's editorial comments:

"The respect that the medical profession enjoys must in large measure be attributed to the fact that medicine has a well developed system of ethics, which is based on the recognition of the fact that the parties to the physician-patient relationship are not on equal footing. By the very nature of illness and the method of restoring an individual to health, the patient must place his trust in the physician. The physician must maintain that trust by keeping up his *competence*, his *knowledge* and his *skills*, and he must not permit his concept of professionalism to stagnate."

This is Edwin J. Holman: "Medicine's system of ethics needs no apology. It does, however, lack widespread public appreciation. Is the medical profession ethically remiss for failing to extol its virtue in this respect?"

I quote him simply in pleading for continuing competence, not continuing harassment.

153 West 11th Street (10011)

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Radiologic Seminar CLXVII: Trichobezoar

FRANK L. SCHMIDT, M.D.
Pass Christian, Mississippi

THE DISCOVERY of a foreign body is usually interesting to radiologists and we have all seen many oddities. The presence of a bezoar is frequently a surprise and its diagnosis gratifying by ruling out a more serious tumor or carcinoma.

Trichobezoar or "hair ball" results from the repeated swallowing of hair, frequently the patient's own, and its retention and accretion in the intestinal tract. Most are found in the stomach but some have been reported elsewhere in the intestinal tract producing obstruction.

Symptoms range from foul breath to epigastric pain, nausea, and vomiting. Clinical findings may include a palpable mass, weight loss, and signs of gastrointestinal blood loss if ulceration occurs.¹ The combination of physical and radiographic findings may initially suggest gastric carcinoma but a pertinent history of swallowing hair, persimmons, or other fiber materials will alert the physician to a benign and happier diagnosis.

The differentiation of phytobezoar (vegetable fiber) is important because of some success of non-operative treatment. Oral enzymatic therapy with papain and cellulase has been reported by Stanten and Peters.² Henderson has reported repeated treatments by gastroscopy and lavage of a recurrent phytobezoar in a post subtotal gastrectomy and vagotomy patient.³

The radiological findings are most important in arriving at the correct diagnosis of bezoar. An intragastric mass may be outlined by barium or air and it retains barium enmeshed in its honeycomb-like surface. A neoplasm is excluded by demonstrating that the bezoar does not arise from the gastric wall and has no connection with it.⁴

The following case demonstrates some of the typical clinical and radiological findings.

An eight-year-old female was admitted with a history of epigastric pain, anorexia, vomiting and weight loss. Examination showed a movable non-tender 12 x 4 cm. epigastric mass. There was also a history of hair pulling and alopecia at age four years, but she had normal hair at the time of admission. There was evidence of weight loss and poor nutrition. The initial clinical impression was abdominal tumor. Lab work showed hematocrit of 35 per cent but was otherwise normal. Chest and abdominal radiographs and intravenous urogram failed to elucidate the nature of the mass. Gastrointestinal series showed a stomach-shaped filling defect without attachment to the gastric wall with retention of the barium along the surface of the defect on the delayed films. Figures 1 and 2 show the mass outlined by barium. Figure 3 is a radiograph of the specimen.

SUMMARY

A short resume of the clinical and radiologic findings of a case of trichobezoar is given. ★★★

Rt. 2, Box 45 (39571)



Figure 1. AP view of the barium filled stomach showing an irregular filling defect throughout the gastric cavity.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Singing River Hospital,
Pascagoula, MS.



Figure 2. The filling defect within the gastric lumen does not have an attachment to the gastric wall.



Figure 3. Radiograph of the specimen after removal from the stomach. Note that the trichobezoar has retained barium. Its contour conforms with the gastric lumen.

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Interested in "The Facts" about lung diseases and respiratory problems? As a Christmas Seal service, the Mississippi Lung Association can supply informative leaflets to physicians and/or patients on these . . . matters of life and breath. Address requests to: P.O. Box 9865, Jackson, MS 39206.



The President Speaking

“On the National Scene”

LYNE S. GAMBLE, M.D.
Greenville, Mississippi

HEALTH LEGISLATION which is considered to have high priority during the present session of Congress includes: (1) A national catastrophic illness program, (2) The “Kiddie Care” Plan, sort of a Medicare program for infants, children, and mothers, and (3) The Talmadge Bill for Medicare and Medicaid Administrative Reform.

Proposals for a national Catastrophic Insurance Program have been bouncing around Congress for the last several years. Of all the NHI proposals, this would be the least expensive to implement and with the stated goal of President Carter and some leading Democratic congressmen “to phase in” a NHI program over a period of several years, it is reasonable to expect catastrophic coverage as a first “phase in” step.

A national “Kiddie Care” plan or some combination of a national maternal and child health care program is also another great possibility for a “phased in” approach to NHI. Category grants for maternal and child care programs have long been popular with Congress and a sweeping health program to address this real area of need will gather a lot of support from Congress, the public, and various professional health groups.

According to Senator Herman Talmadge (D-Ga.) “basic kinds of administrative and payment charges—are absolutely necessary prior to any expansion of the federal role in providing more health insurance to more people.” He states that his Medicare and Medicaid Administrative Reform Act is being introduced in order to prevent arbitrary controls on payments. Among other things the measure would: (1) Establish within HEW an officer known as the Inspector General for Health Administration, who would be responsible for reviewing, inspecting, and auditing all federal health care programs under the Social Security Act to ascertain efficiency and economy of administration, consonance with the law and attainment of objectives; (2) Revise the Medicaid Law to provide that effective July 1, 1977, the amount payable for physician services provided outside a hospital setting would be not less than 80 per cent of the Medicare reasonable charge; (3) Set up two classes of physicians under Medicare. A “participating physician” who would agree to accept all Medicare reimbursement for his services on the basis of an assignment. “Participating physicians” would be permitted to submit claims on a multiple listing basis (rather than on an individual patient basis) and would be allowed an “administrative cost savings allowance” of

(Continued on page 39)

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVIII, NUMBER 2

FEBRUARY 1977



EDITORIALS

Medicare-Medicaid Fees

Travelers Medicare has recently issued prevailing charge fee profiles for physicians' services in Mississippi which will be applicable during fiscal year 1978. The prevailing charge profiles are based on calendar year 1975 charge data from Mississippi physicians in the two Medicare fee areas for the state.

Under Medicare regulations physicians' services will be reimbursed during this fiscal year based on the lesser of: (1) The actual charge submitted for a service; (2) the physician's customary (median) charge for the service during calendar year 1975 as shown by his fee profile with Travelers Medicare; or (3) the 75th percentile prevailing charge for the service among physicians in the fee area during calendar year 1975 that does not exceed the economic index limitation.

Both the Mississippi State Medical Association and the American Medical Association have strongly criticized the wide disparity in Medicare and Medicaid reimbursement between various areas of the country. Such disparity often means that physicians in Mississippi receive about one-half the professional fee for the same service performed by physicians in other parts of the country. The wide difference has been cited as a barrier to physicians locating their practices in Mississippi.

The American Medical Association has officially gone on record to redouble its efforts to have the Medicare "Economic Index" regulation repealed and urged physicians to bill their appropriate fees for services even though third party payors such as Medicare reduce the amount of payment.

A listing of Medicare prevailing fees and Medicaid fees for Mississippi for selected procedures follows. Medicare area II includes Meridian, Jackson,

Hattiesburg, Tupelo and the Gulf Coast; Medicare Area I is the rest of the state.

<i>Procedure</i>	<i>Medicare Area I</i>	<i>Medicare Area II</i>	<i>Medicaid</i>
Initial office visit	\$ 10.00	\$ 12.00	\$ 6.00
Comprehensive consultation	38.00	44.70	28.00
X-ray, upper G.I.	44.70	40.00	28.00
Complete blood count	9.00	10.00	4.80
Hemorrhoidectomy	225.00	258.00	105.00
Radical mastectomy	526.60	517.10	200.00
Dilation and curettage	116.00	141.00	50.00
Distal radical fracture, closed reduction	150.40	164.50	60.00

CHARLES L. MATHEWS
Executive Secretary

The President Speaking

(Continued)

\$1.00 for each patient listed. In addition, at least 50 per cent of the estimated amount due on each multiple-listing claim form would be paid within five days of receipt of the physician's claim (subject to later adjustments). A "non-participating physician" would not be eligible to accept assignment with respect to any patient. (4) Prohibit Medicare and Medicaid from recognizing percentage arrangements in which hospital based specialists receive a specified percentage of the revenues or income from all laboratory or x-ray work, regardless of his direct "personal service or involvement."

Finally, although not having high priority as a new program, the authority for the National Health Planning and Resources Development Act (Public Law 93-641) will expire in 1977 and Congress can be expected to extend, modify, or repeal this act. The latter, of course, is probably wishful thinking.

In my opinion, in addition to the almost unlimited authority delegated to the Secretary of HEW by this act, another undesirable feature is the granting of governmental powers to private non-profit corporations called Health Systems Agencies. Policy and decision making on the use of public funds should be performed by individuals and/or groups having an identifiable and responsible linkage to elected public officials. Hopefully, Congress will amend the act to provide for this. ★★★

Medico-Legal Brief

FORMER PATIENT SUES HOSPITAL AFTER DENIAL OF REQUEST TO EXAMINE RECORDS

A former patient who was unable to obtain a copy of his hospital bill without paying a \$5 fee could not recover for intentional infliction of mental distress, an Illinois appellate court ruled. The court did find, however, that the patient had a cause of action for breach of statutory duty to furnish records.

The patient, an attorney, requested a copy of the bill after his release. When the hospital informed him that there would be a \$5 charge, he wrote to the hospital administrator, stating his objection. He received an answer from the hospital controller informing him that the one free itemized bill that he was entitled to had been sent to Medicare and that another would cost him \$5.

On the letterhead of his law firm, the patient wrote to the hospital, demanding permission to examine and copy his records. The hospital medical record librarian replied, stating that he would receive an abstract of his case history for a \$5 fee. He paid the fee, but received a copy of his bill only.

The patient discontinued his attempts to examine or obtain copies of his record. Instead, he brought an action against the hospital and its supervising personnel, seeking damages for monetary expense and for severe mental and emotional anguish. The trial court dismissed the suit, finding that the complaint failed to state a cause of action.

On appeal, the court found that neither the small charge of \$5 for a copy of the hospital bill, nor the hospital's alleged refusal to produce the patient's records for examination and copying, could be calculated to cause "severe emotional distress to a person of ordinary sensibilities," as required by law to

recover damages for emotional distress. Moreover, the court found that the hospital did not have a common law duty to furnish a copy of the bill without charge.

The court did find, however, that the patient's allegations stated a cause of action for violation of the statutory duty to permit examination and copying of hospital records by a patient's attorney or physician. Therefore, the court sent the case back for further proceedings with regard to the hospital's failure to provide access to the patient's records.—*Rabens v. Jackson Park Hospital Foundation*, 351 N.E.2d 276 (Ill.App.Ct., June 25, 1976)



PERSONALS

RALPH E. ABRAHAM of Hattiesburg and H. DAVIS DEAR, JR., of Jackson have been inducted as Fellows of the American College of Chest Physicians.

BERT E. BRADFORD of McComb has been elected to fellowship in the American Academy of Pediatrics.

B. H. BUCHANAN, EARL E. WHITWELL and MITCHELL MASSEY, all of Tupelo, announce the relocation of their offices for the practice of orthopedic surgery to 448 Eason Boulevard West.

GUY CAMPBELL of Jackson delivered the fifth annual Henry Boswell Lecture at the University Medical Center. His topic was "Tuberculosis: Consumption to Nonchalance."

JOE CAMPBELL, JR., of Clarksdale is the new president of the Clarksdale and Six Counties Medical Society. HENRY MCRORY is secretary and JACK SARTIN is president-elect.

HERMAN R. CROWDER, III, has associated with Anesthesia Associates of Jackson for the practice of anesthesiology with offices at 1600 North State Street in the Medical Plaza Building.

JAMES O. GILMORE of Oxford announces the association of JOHN W. SMOOT in the general practice of medicine.

J. EDWARD HILL of Hollandale spoke at a seminar of the Department of Social and Preventive Medicine at Harvard University Medical School. His topic, "Maternal-Child Health Care in Rural Mississippi," centered around the service directed and staffed by nurse-midwives in Hollandale.

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LUCIEN R. HODGES of Jackson has been named president of the medical staff of Mississippi Baptist Medical Center in 1977. EARL FYKE is president-elect and ROBERT TYSON is secretary-treasurer.

THOMAS L. KILGORE, JR., of Jackson has been inducted into fellowship in the American College of Surgeons.

JOHN PAUL LEE of Forest announces the association of JERRY L. STENNETT for the general practice of medicine at 285 E. First Street.

JAMES A. LAUDERDALE of Meridian is president of the East Mississippi Medical Society. GEORGE L. ARRINGTON, JR., of Meridian is secretary and DAVID RICHARDSON of Louisville is president-elect.

JAMES O. MANNING of Jackson, president of the Mississippi Society of Sports Medicine, chaired the local physicians' committee that took part in a series of Sports Medicine Clinics cosponsored by the Mississippi Association of Coaches.

W. THOMAS MCCRANEY of Jackson was guest speaker for the December meeting of the Child Health Care Advocates. He discussed scoliosis.

ROBERT L. MCKINLEY, JR., has associated with WILLIAM D. BRIDGES of Pascagoula for the practice of psychiatry at Suite 308, Doctors Plaza.

DUDLEY MUTZIGER of Natchez is new president of the Homochitto Valley Medical Society. WALTER T. COLBERT is secretary and DAVID BALL is president-elect.

JOHN E. RAWSON of Jackson and UMC is serving as chairman of this year's March of Dimes campaign in Mississippi.

THOMAS R. SINGLEY of Pascagoula is new president of the Singing River Medical Society. CLYDE H. GUNN, JR., of Moss Point is secretary and DEWEY H. LANE of Pascagoula is president-elect.

JAMES O. STEPHENS of Magee is new president of Central Medical Society. FRED L. McMILLAN of Jackson is secretary and ELLIS M. MOFFITT of Jackson is president-elect.

JOHN SUARES of Greenville is new president of Delta Medical Society. WALTER ROSE of Indianola is secretary and FRED SANDIFER of Greenwood is president-elect.

The Vicksburg Clinic has recently received accreditation by the American Group Practice Association.

RAY WESSON of Biloxi is new president of the Coast Counties Medical Society. H. S. BARRETT of Gulfport is secretary and BEN KITCHINGS of Long Beach is president-elect.



LETTERS

SIRS: Early reporting of venereal disease cases by private physicians to local health departments is an essential part of any effective control program. Although some physicians hesitate or refuse to report their private patients, Mississippi regulations, clearly supported by law, require such reporting. It is apparent that reporting requirements will become more stringent as medical care delivery systems continue to evolve. A more immediate and compelling reason for early reporting is the far-reaching effect on the lives of other people when a case is lost to follow-up.

As the result of nonreporting, sexual contacts of cases continue the spread of the disease. Each year, we find increasing numbers of patients in our epidemiologic chains of infection, who were treated earlier but not reported. The so-called "epidemiologic follow-up" requires the interview of patients and the locating of their contacts. This has been proven effective in the control of syphilis and is an established standard of practice. It is essential that this process be applied to all cases of early syphilis and a report to the local health department is required for this purpose.

All reports are treated in strict confidence. No private patient is contacted by health department personnel before consulting with the reporting physician.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

Cancer Deaths Are Higher Among Nonwhites

A recent study by National Cancer Institute scientists reports that nonwhites suffer a proportionately higher death rate from cancer than whites and certain types of cancer strike some races with greater frequency than others.

The study also shows that the occurrence of different cancers among nonwhites varies throughout

the nation. A situation found for whites in a similar study released in 1975.

Compared to other racial groups, blacks have proportionately higher rates for cancers of the mouth and throat, esophagus, stomach, pancreas, larynx, lung, bladder, cervix and a kind of bone marrow cancer called multiple myeloma.

Whites have higher mortality rates than blacks for cancer of the colon and rectum, breast, ovary, testis, kidney, skin, brain and lymph system, as well as leukemia.


Geographically, both whites and nonwhites show higher rates for cancers of the breast, colon, rectum, esophagus, larynx, bladder and ovary in the North and low rates in the South.


The incidence of lung cancer was high for both white and nonwhite males in northern areas, but lower along the Gulf and Atlantic Coast for nonwhites.


Esophageal cancer rates were high in the urban North for white and nonwhite males but only nonwhites showed high rates along southern coastal areas.



DEATHS

 BROWN, GEORGE ARNOLD, Water Valley. Born Dalhousie, Canada, May 3, 1891; M.D., Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1914; interned, same, one year, eight-month surgery residency, same; died Nov. 30, 1976, age 85.

 LEWIS, NATHAN B., Vicksburg. Born East Las Vegas, NM, May 7, 1905; M.D., University of Tennessee College of Medicine, Memphis, 1929; interned Jewish Hospital, St. Louis, MO, one year; surgery residency, Pacific Hospital, St. Louis, MO, 1930-31; surgery residency, Vicksburg Infirmary, Vicksburg, MS, 1931-36; died Nov. 30, 1976, age 71.

 MILNE, J. A., Jackson. Born Woodburn, Nova Scotia, June 14, 1900; M.D., Dalhousie University, Halifax, Nova Scotia, 1924; interned Manchester Royal Infirmary, Manchester, England, one year; emeritus member of MSMA and AMA; died Dec. 11, 1976, age 76.

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NEW MEMBERS

BOSIO, BRUNER B., JR., Pascagoula. Born New Orleans, Dec. 1, 1945; M.D., Tulane University School of Medicine, New Orleans, 1970; interned University of Colorado Medical Center, Denver, one year; ob-gyn residency, same, three years; elected by Singing River Medical Society.

BOSTWICK, F. HINES, Jackson. Born Ripley, MS, Nov. 11, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned Miami, FL, one year; pathology residency, Medical College of Georgia, Augusta, one year; pathology residency, UMC, Jackson, MS, 1968-70; pathology residency, University of Southern California, 1970-72; elected by Central Medical Society.

BRUCE, JAMES A., JR., Oxford. Born Kosciusko, MS, April 21, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned St. Joseph Hospital, Houston, TX, one year; ophthalmology residency, University of Tennessee, Memphis, 1973-75; elected by North Mississippi Medical Society.

COCKRELL, WAYNE P., Pascagoula. Born West Point, MS, Oct. 1, 1931; M.D., Harvard Medical College, Boston, MA, 1956; interned UMC, Jackson, MS, one year; elected by Singing River Medical Society.

COGGIN, ROBERT L., Grenada. Born Tupelo, MS, April 4, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1973; internship and pediatric residency, University Medical Center, Jackson, MS, 1973-76; elected by North Central District Medical Society.

DUNCAN, ROY D., Pascagoula. Born Tupelo, MS, April 3, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Wilford Hall USAF Medical Center, Lackland, TX, one year; urology residency, same, 1972-75; elected by Singing River Medical Society.

GOUDELOCK, JOHN C., New Albany. Born Bruce, MS, July 22, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned Greenville General Hospital, Greenville, SC, one year; surgery residency, same, one year; surgery residency, Cincinnati General Hospital, Cincinnati, OH, one year; surgery residency, Greenville General Hospital,

Greenville, SC, 1972-73; surgery residency, Baptist Hospital, Nashville, TN, 1973-75; elected by Northeast Mississippi Medical Society.

HAND, WILLIAM L., Meridian. Born New Orleans, June 7, 1939; M.D., Tulane University School of Medicine, New Orleans, 1965; interned McLeod Infirmary, Florence, SC, one year; surgery residency, Ochsner Foundation Hospital, New Orleans, 1968-72; hip surgery fellowship, New England Baptist Hospital, Boston, MA, Jan. 1972-July 1972; elected by East Mississippi Medical Society.

HASELL, JOHN F., Jackson. Born Moss Point, MS, Oct. 30, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned and family medicine residency, same, 1973-76; elected by Central Medical Society.

PAYNE, PATRICIA, Jackson. Born Kosciusko, MS, Jan. 28, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned Hospital of the University of Pennsylvania, one year; general surgery residency, same, one year; elected by Central Medical Society.

SAVARESE, CHARLES J., Tchula. Born Charlotte, NC, Jan. 11, 1920; M.D., George Washington University School of Medicine, Washington, DC, 1950; interned Naval Hospital, Bethesda, MD, one year; internal medicine residency, same, one year; internal medicine residency, Rodriguez General Hospital, San Juan, Puerto Rico, 1951-53; fellowship in cardiology, George Washington University, Washington, DC, 1953-54; elected by Delta Medical Society.

YATES, ALLEN RICHARD, Jackson. Born Memphis, TN, Oct. 5, 1944; M.D., University of Tennessee College of Medicine, Memphis, 1969; interned Grady Memorial Hospital, Atlanta, one year; radiology residency, UMC, Jackson, MS, 1972-75; elected by Central Medical Society.

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Choledyl® (oxtriphylline) Tablets and Elixir CAUTION: Federal law prohibits dispensing without prescription. Each partially enteric coated tablet contains 200 mg or 100 mg oxtriphylline. Each teaspoonful of the elixir contains 100 mg oxtriphylline; alcohol 20%. **Indications.** Choledyl (oxtriphylline) is indicated for relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema. **Warning.** Use in pregnancy—animal studies revealed no evidence of teratogenic potential. Safety in human pregnancy has not been established; use during lactation or in patients who are or who may become pregnant requires that the potential benefits of the drug be weighed against its possible hazards to the mother and child. **Precautions.** Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children. **Adverse Reactions.** Gastric distress and, occasionally, palpitation and CNS stimulation have been reported. **Dosage.** Average adult dosage: Tablets—200 mg, 4 times a day; Elixir—two teaspoonfuls, 4 times a day. **Supplied.** 200 mg yellow, partially enteric coated tablets in bottles of 100 (N 0047-0211-51) and 1000 (N 0047-0211-60); Unit Dose—200 mg tablets (N 0047-0211-11); 100 mg red, partially enteric coated tablets in bottles of 100 (N 0047-0210-51). Elixir—bottles of 16 fl oz (1 pint) 474 ml (N 0047-0215-16). **Toxicity.** Oxtriphylline, aminophylline and caffeine appear to be more toxic to newborn than to adult rats. No teratogenic effects have been seen. Full information is available on request.

CH-GP-51-4/C



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CHOLEDYL®

(OXTRIPHYLLINE) SINGLE-ENTITY
BRONCHODILATION
MINIMAL GASTRIC DISCOMFORT

Famous Fighters



JOHN L. SULLIVAN
Bare-knuckles heavyweight champion
1882-1892

NEOSPORIN® Ointment (polymyxin B-bacitracin-neomycin) is a famous fighter, too.

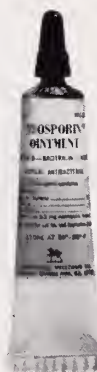
Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) oil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to



neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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THE LITERATURE

Book Review

Coping With Food Allergy. By Claude A. Frazier, M.D. 334 pages with illustrations. New York: Quadrangle Press, 1974.

This is an excellent book written primarily for the patient with food allergy.

The first five chapters deal with the mechanisms of food allergy, the various body systems involved, but without mechanisms explained simply because no one knows the mechanisms.

There are three chapters each devoted to common foods: milk, wheat and egg. These are the most difficult foods to avoid. There are excellent recipes and substitutes in these chapters.

The remainder of the book is devoted to recipes and food lists which the patient with allergic food problems can manipulate to his own tastes.

The chapter on food additives is well worth reading by both physician and patient. Aspirin, for example, is found in a natural state in some foods and added to others as a preservative.

The book is recommended to the patient with complex food problems. The cost, according to the inside folder, is \$9.95.

ELLIS M. MOFFITT, M.D.
Jackson, MS



POSTGRADUATE CALENDAR

Feb. 9-11, 1977

Mar. 9-11, 1977

NEWBORN CARE FOR PHYSICIANS

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine and the University Medical Center Division of Continuing Health Professional Education, with support from the Bureau of Community Health Services, Department of Health, Education and Welfare.

Coordinator:

Gwendolyn Bussa, M.N., assistant professor of nursing, University of Mississippi School of Nursing.

A three-day seminar for physicians who deal with the newborn, this course will include gestational age assessment, respiratory disease, hyperbilirubinemia, genetics, viral and bacterial infections, fluids and electrolyte imbalance, hematological problems and other problems confronting the neonate. Fee: \$75. Credit: 19 contact hours, 1.9 CEU, Category I, AMA; AAFP.

Feb. 7-9, 1977

UROLOGY INTENSIVE COURSE

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education with support from Mississippi Regional Medical Program.

Coordinator:

W. Lamar Weems, M.D., professor of medicine and chief, division of urology, University of Mississippi School of Medicine.

This two-and-one-half day intensive course is structured to give the primary physician an overview of current methods of diagnosis and treatment of common urological diseases. The topics to be covered include urinary tract infections, benign prostatic hyperplasia, cancer of the prostate, kidney and testicles, stones, office urology, urethral strictures, trauma, infertility and impotence, catheter care and the neurogenic bladder, and a review of common urologic X-rays. Fee: \$75. Credit: 20 contact hours, 2.0 CEU, Category I, AMA; AAFP.

Feb. 14-18, 1977

NEPHROLOGY INTENSIVE COURSE

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program.

Coordinator:

John D. Bower, M.D., professor of medicine, University of Mississippi School of Medicine; director, artificial kidney unit; and assistant professor,

physiology-biophysics, University Medical Center.

This clinically oriented one-week course for physicians will emphasize the reversible and treatable forms of kidney disease. It provides an in-depth analysis of acute kidney failure management and control of the reversible features of chronic kidney disease. Instruction will cover the management of pyelonephritis, glomerulonephritis, nephrotic syndrome, fluid and electrolyte problems, and acid base balance. Participants will become familiar with physiology, pathology, radiology, immunology, urology, transplantation and hemodialysis in clinical nephrology. Fee: \$125. Credit: 40 contact hours, 4.0 CEU, Category I, AMA; AAFP.

Feb. 17, 1977

EARLY DETECTION OF HEAD AND NECK CANCER
Holiday Inn, McComb

Sponsored by the University of Mississippi School of Nursing, University Medical Center Division of Continuing Health Professional Education and the National Cancer Institute Project for Head and Neck Cancer in cooperation with the American Cancer Society, Mississippi Division, Inc.

Coordinator:

Dale E. Clark, M.M.S., coordinator, Mississippi Head and Neck Cancer Network, the University of Mississippi Medical Center.

Open to physicians, dentists, RNs, LPNs, dental hygienists and dental auxiliaries, this session is one in a series planned to give health professionals new information about head and neck cancer, with emphasis on early detection, coordinated treatment and total rehabilitation. Program objectives are to identify, field test and evaluate available and new methods in a limited number of communities for the detection, diagnosis, staging, treatment and rehabilitation of patients with head and neck cancer. Supportive data collected will be used to determine the program's practicality and acceptability prior to dissemination into wider cancer control community programs. Other sessions are planned for Meridian, April 20 and Greenville, May 10. Fee: \$10. Credit: 6 contact hours, .6 CEU, Category I, AMA; AAFP.

Mar. 2-4, 1977

OTOLARYNGOLOGY

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical

Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program.

Coordinator:

Godfrey E. Arnold, M.D., professor of surgery and chief, division of otolaryngology, and associate professor of physiology-biophysics, University Medical Center.

This two-day clinically oriented course will deal with basic knowledge of ear, nose and throat problems as needed by the primary care physician. Lecture topics include ENT anatomy, orofacial infections, oral cavity lesions, maxillofacial trauma, epistaxis, head and neck tumors, ENT pathology, dizziness and vertigo, laryngeal paralysis, laryngeal disease, otitis externa and media, and otogenic complications. Instruction includes a tour through the UMC audiologic and vestibular laboratories, and patients will be presented at Grand Rounds. The schedule allows ample time for discussion of all lecture topics, and clinical problems presented by participants will receive special attention. The course will begin at 11:30 a.m., Wednesday, Mar. 2, and end at 12 noon, Friday, Mar. 4. Fee: \$50. Credit: 24 contact hours, 2.4 CEU, Category I, AMA; AAFP.

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers intensive refresher courses to meet physicians' clinical practice needs in the specialties most requested. The Mississippi Regional Medical Program partially supports the series open to all physicians. Intensive courses are eligible for AMA Physician Recognition Award, Category I, credit. Enrollment is limited, and applications are accepted in the order received. All correspondence should be addressed to Continuing Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

FUTURE CALENDAR

April 11-15, 1977

NEWBORN CARE FOR PHYSICIANS

University Medical Center, Jackson

April 11-15, 1977

PULMONARY MEDICINE INTENSIVE COURSE

University Medical Center, Jackson

April 20, 1977

HEAD AND NECK CANCER WORKSHOP

Meridian

April 26, 1977

MISSISSIPPI THORACIC SOCIETY ANNUAL MEETING

University Medical Center, Jackson



The 109th Annual Session of MSMA Is Set for May 2-5 at Biloxi

Plans are being finalized for the 109th Annual Session of the Mississippi State Medical Association, set for May 2-5, 1977, at the Sheraton-Biloxi.

The 12 scientific sections of the Council on Scientific Assembly are planning informative and stimulating programs, according to council chairman, Dr. J. Elmer Nix of Jackson.



Dr. Nix

Additional postgraduate offerings include a Mississippi Urological Society sponsored genitourinary seminar on Sunday afternoon, May 1, and an array of scientific and technical exhibits.

Some 14 medical specialty and related organizations plan to host concurrent meetings, social and scientific, during the MSMA annual session, said Dr. Nix.

Business of the association will be conducted in the House of Delegates meetings on May 2 and May 5 and the reference committee hearings on May 2. A special feature will be an address by the president of the American Medical Association, Dr. Richard E. Palmer of Alexandria, VA, on Monday, May 2.

The University of Mississippi, Tulane and the University of Tennessee medical alumni associations are planning social events for Monday evening, May 2, at the Sheraton.

Also meeting in conjunction with the MSMA convention will be the 54th annual session of the Mississippi State Medical Association Auxiliary. Mrs. W. A. Brown, Jr., of Mathiston is president of

the auxiliary and Mrs. William Hilbun of Meridian is president-elect. Special guest at the auxiliary meeting will be Mrs. Norman H. Gardner, president of the AMA Auxiliary.

All reservations at the Sheraton will be made through MSMA and members of the association will receive priority.

New this year will be a tennis tournament for physicians and spouses to be conducted on the Sheraton's four new courts. Chairman of this event is Dr. Henry Tyler of Jackson.

For more information regarding the convention, write Council on Scientific Assembly, MSMA, P.O. Box 5229, Jackson, MS 39216. The complete annual session program will be published in the April issue of the JOURNAL MSMA.

MHSA Endorses Higher Maternal Care Payments

The Board of Directors of the Mississippi Health Systems Agency, Inc. has gone on record in support of higher Medicaid payments for maternal care as a method for improving the state's maternal and infant mortality rates and preventing child birth defects which cost the state millions of dollars for mental health and rehabilitative services.

The MHSA Board action was prompted by a recommendation from a statewide Advisory Committee on High Risk Maternal and Newborn Care recently designated by MHSA. The committee is composed of representatives from various health professional groups in the state and was sponsored by the Mississippi State Medical Association.



RECENT CHANGES

federal register

**Providing
Drug Information
to Physicians**

**Informational
Bulletin #433-76**

**National
Health
Insurance**

special report
**Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
'MAC' rules**

**Drug
Substitution**

**The Canadian Determinants
of Health Progress**
RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Finch Appointee Takes Optometry Lobbyist Job

Helen St. Clair, a Finch appointee and the wife of one of the top political appointees of Gov. Cliff Finch, has registered as the lobbyist for the Mississippi Optometric Association.

Mrs. St. Clair takes over the position held for the three previous years by her husband, Fred W. St. Clair.

St. Clair resigned as executive director and lobbyist for the optometric association when Finch appointed him head of the Mississippi Welfare Department last summer.

Mrs. St. Clair was appointed by Finch in September to the Governor's Council on Aging.

Mrs. St. Clair, whose association presently is engaged in a heated battle with state ophthalmologists over legislation, said she saw no conflict of interest in her position as lobbyist and her and her husband's roles in the executive branch of state government.

However, state ophthalmologist leader Dr. Robert O. May of Jackson said Mrs. St. Clair's position "suggests a lot of things" to him.

"To me, this is a crucial conflict of interest in that (St. Clair and Mrs. St. Clair) are very active in state politics and state health matters."

The office of Gov. Cliff Finch said the governor reviewed cases such as this on an individual basis and would need all of the background of the situation before making a statement.

St. Clair, before he resigned as executive secretary of the optometric association, was instrumental in organizing the Mississippi Health Systems Agency, a federally mandated agency that handles federal health funds allocated to Mississippi.

The optometric association currently is quarreling with the Mississippi Eye, Ear, Nose and Throat Association, which is associated with the Mississippi State Medical Association, over the use of drugs by optometrists for diagnostic purposes.

Optometry is defined by Webster as a profession involving examination of eyes for defects and faults, and prescribing correctional lenses and exercises, but not including the use of drugs or surgery.

An ophthalmologist is a physician who specializes in the study and treatment of defects and diseases of the eye.

The main thrust of St. Clair's legislative activities when he was lobbyist for the optometric association

centered on passage of legislation to remove drug usage restrictions on optometrists, lobbying records filed with the Secretary of State show.

Mrs. St. Clair said Thursday that her association would make a similar thrust again this year.

In fact, the Mississippi Optometric Association has scheduled a legislative reception and dinner Monday (Jan. 10) at the Jackson Hilton. About 300 persons are expected to attend, Mrs. St. Clair said.

The reception and dinner should cost approximately \$2,000, based on estimates quoted by the Hilton.

Mrs. St. Clair said she once offered to resign her position as executive secretary and lobbyist for the optometric association but that officials of the organization did not think that was necessary.

Baldwyn optometrist John White, president of the Mississippi Optometric Association, said he did not see a potential conflict of interest in Mrs. St. Clair's role with the association.

"This is the day of women's lib," he said. "He (St. Clair) works with the executive branch of government and has nothing to do with the legislature."

Mrs. St. Clair said that having a husband as her lobbying predecessor and as commissioner of welfare could be a "handicap" because she would be identified as "Mrs. Fred St. Clair" and not "Helen St. Clair."

Mrs. St. Clair said she had "tried to stay away from the Capitol as much as possible" and had hoped that legislative discussion of the optometry bill would be low-key.

However, based on pre-legislative exchange of press releases by the optometrists and ophthalmologists, the discussion will be significant.

The optometric association has claimed that Mississippians suffer from inadequate eye care because of the "restrictions" that are placed on services offered by optometrists. The association claims there are just 25 ophthalmologists in the entire state.

The ophthalmologists, on the other hand, claim that optometry is "a measuring science" and that there are "dangers" inherent in legislation allowing use of drugs by "non-medical personnel." The ophthalmologists also point out there are nearly 80 practicing ophthalmologists in the state.

Several states already have passed legislation allowing optometrists to use drugs in their practice. Similar legislation has been introduced in the Mississippi Legislature every session since 1974.

The legislation has died every year, although last year the Senate approved a measure that died on the

Emergency Medical Care Unit Opens at Capitol

The MSMA Emergency Medical Care Unit in the Capitol Building at Jackson opened Jan. 4, 1977, for the thirteenth consecutive year of service during the 1977 Regular Session of the Legislature.

The association's public service project is again staffed by Mavis Barlow, R.N., of Florence. Physician's services are provided by volunteer Doctors of the Day.

Response by the MSMA membership to DOD assignment requests has been excellent, according to Dr. Charles R. Jenkins of Laurel, chairman of the Council on Legislation.

Legislative leaders have praised the service which costs the state nothing. Physicians contribute their services, and association funds are used to defray direct expenses. Some pharmaceutical firms donate supplies and drugs, and the state furnishes the unit space, a telephone, utilities and janitorial services.

Mrs. Barlow said the unit's practice is brisk. Conditions seen in previous years ranged from the common cold to heart attacks. The EMCU serves the legislators and Capitol employees.



Dr. Lyne S. Gamble of Greenville, MSMA president, is assisted by EMCU nurse Mavis Barlow during his tenure as the volunteer Doctor of the Day at the Capitol.

Study Urged of Surgical Consultation Programs

MSMA's Council on Medical Service has called for more study of surgical consultation programs for elective surgery before such programs are expanded.

The council in response to a request from a major insurance carrier as to the association's views about surgical consultation programs stated that "the medical and economic results of such programs were at this time unknown and that results of present programs should be carefully examined before the programs were generally expanded."

Surgical consultation programs, which several of the nation's major health insurance carriers are considering, provide that policyholders may seek a second consultation which the carrier will pay for when elective surgery is recommended. Oftentimes the programs also provide that the policyholder will seek consultation from a selected list of "surgical specialists." The Council on Medical Service noted that none of the programs had been in operation long enough to provide data on either their medical or economic results.

Fifth Annual UMC Benefit Is Planned

The fifth annual University of Mississippi Medical Center benefit gala will feature Leroy Jones and his Hurricane Brass Band Feb. 26 at the Northpointe Barn, from 8 p.m. until midnight.

The New Orleans group, called the only true successors of the Olympia Brass Band, led the Mississippi Arts Festival parade this spring and played in Capital Street's "preservation hall" during the festival.

Traditionally known as Spring Fling, this year's gala is "An Evening at the Barn" and features dancing and a buffet supper.

Chairmen for the UMC Auxiliary Board sponsored event are Mrs. B. Rowc Byers, Mrs. John Hudson, and Mrs. William T. Newell.

The benefit is a joint project of the Medical Center Women's Club, University Hospital Auxiliary, Intern and Resident Wives Auxiliary and Student Wives Auxiliary.

Proceeds this year go to the auxiliaries' ongoing patient needs fund.

Dr. Zollinger Headlines UMC Surgical Forum

Dr. Robert M. Zollinger, internationally known surgeon and professor and chairman emeritus, department of surgery, Ohio State University College of Medicine, will headline Surgical Forum IV.

The University of Mississippi Medical Center seminar is Mar. 10-12 at the Holiday Inn in Jackson. Forum coordinators are Dr. James D. Hardy, UMC professor of surgery and department chairman, and Dr. William O. Barnett, UMC professor of surgery.

Dr. Zollinger and ten other noted surgeons will join Medical Center faculty in discussions on general, pancreatic and malignant disease problems.

Dr. Zollinger has served as president of the American College of Surgeons and American Surgical Association. He is also a past chairman of the American Board of Surgery and a former president and founding member of the Society of University Surgeons and Society for Surgery of the Alimentary Tract.

Author of or contributor to more than 230 scientific papers and books, Dr. Zollinger has been editor-in-chief of *The American Journal of Surgery* since 1958.

Other guest lecturers include Dr. Ben Eiseman, professor and director, department of surgery, City and County of Denver, Department of Health and Hospitals, Denver, CO, author of more than 340 scientific publications; Dr. Mark M. Ravitch, professor of surgery, University of Pittsburgh School of Medicine, and three-time president of the surgical section of the American Academy of Pediatrics; and Mississippi native Dr. Hiram C. Polk, Jr., professor and chairman, department of surgery, University of Louisville School of Medicine.

Also Dr. Robert E. Hermann, head, department of general surgery, the Cleveland Clinic Foundation; Dr. Richard G. Martin, surgeon and chief, section of surgery, University of Texas M. D. Anderson Hospital and Tumor Institute, and professor of surgery, University of Texas Graduate School of Biomedical Sciences; and Dr. Daniel C. Riordan, clinical professor of orthopedics, Tulane University School of Medicine.

Others are Dr. G. Thomas Shires, professor of surgery and chairman of the department, Cornell University Medical College, and a former chairman

of the American Board of Surgery; Dr. David Skinner, Dallas B. Phemister Professor of Surgery, University of Chicago Pritzker School of Medicine, and professor and chairman, department of surgery, University of Chicago Hospitals and Clinics.

Also Dr. W. Dean Warren, Joseph B. Whitehead Professor and chairman, department of surgery, Emory University School of Medicine, president of the Allen O. Whipple Surgical Society; and Dr. Richard E. Wilson, professor of surgery, Harvard Medical School, and chief of surgical oncology, Peter Bent Brigham Hospital and Sidney Farber Cancer Institute, Boston.

UMC participants are Vice Chancellor Dr. Norman C. Nelson, dean of the school of medicine and professor of surgery; Dr. Richard C. Miller, professor of surgery; Dr. Richard J. Field, Jr., clinical assistant professor of surgery; Dr. J. Harvey Johnston, Jr., clinical professor of surgery; Dr. W. Couper Shands, clinical associate professor of surgery; and Dr. J. Tate Thigpen, assistant professor of medicine.

The School of Medicine and UMC Division of Continuing Health Professional Education sponsor the annual event. Attendance is by invitation, and advance registration is required. For further information write: Continuing Education, 2500 North State Street, Jackson, MS 39216.

Maternal and Newborn Advisory Committee Named

A statewide Committee on High Risk Maternal and Newborn Care has been officially designated as a technical advisory committee to the Mississippi Health Systems Agency, Inc.

The committee, which was sponsored by the association in late 1975, is chaired by Dr. Wendell H. Stockton of Amory and is composed of representatives from various health professional groups in the state. It is to serve as a resource group to evaluate high risk maternal and newborn care and to make recommendations for improved care in this regard.

The following priorities have been established by the committee with respect to its program of work: (1) accurately assess mortality rates of maternal and newborn patients in Mississippi; (2) survey local needs and resources for high risk maternal and newborn care in Mississippi and define results caused by proper medical care not being available; (3) study nationally developed (i.e., American Medical Association, medical specialty organizations) and

locally developed guidelines for high risk maternal and newborn care; (4) establish a statewide model for providing high risk maternal and newborn care based on needs and resources; and (5) establish priorities for providing high risk maternal and newborn care.

MSMA Auxiliary Sponsors Phoenix Project



Mrs. George V. Smith of Jackson, at left, state chairman for the Phoenix Project, Mrs. W. A. Brown of Mathiston, MSMA Auxiliary president, center, and Mrs. Bruce Lucas, the auxiliary member from Kentucky who originated the project discuss Phoenix literature.

Working with the Kidney Foundation of Mississippi, the MSMA Auxiliary recently started the project, which is designed to increase public awareness that transplantation of organs (kidneys and eyes) is successful in Mississippi. The medical auxiliary will work toward educating the public about transplantation and organ donation through talks to clubs and other groups across the state.

Medical Center Adds to Faculty

Two instructors in obstetrics and gynecology have joined the faculty of the University of Mississippi School of Medicine at the Medical Center.

Dr. Ferayl Rashad Rahman and Dr. Ernesto Daniel Ruvinsky assumed their duties in January.

Dr. Gray Hilsman will join the Mississippi medical school's faculty as an instructor in psychiatry and human behavior in March.

The three appointments were announced by UMC Vice Chancellor Dr. Norman C. Nelson on approval of the Board of Trustees of the Institutions of Higher Learning.

Dr. Rahman, who has been an ob-gyn associate at UMC, received the M.D.CH.B. degree in 1968 from the Baghdad University Medical School in India. She completed internships at Baguba Hospital in Iraq and Kansas City General Hospital in Kansas City, MO. Dr. Rahman took her ob-gyn residency training at Al-Major Hospital in Iraq and UMC.

A former UMC ob-gyn associate, Dr. Ruvinsky is a 1963 graduate of J. M. Castro National College in Argentina. He received his medical degree in 1970 from the University of Cordoba Medical School, Cordoba, Argentina. Dr. Ruvinsky did his internship at Hospital Privado in Cordoba. He completed ob-gyn residencies at Hospital Privado and UMC.

Dr. Hilsman, a 1971 graduate of Millsaps College, earned his medical degree at UMC in 1974. He did his psychiatry residency at the Medical Center.

Lower Pot Penalties Proposed

Drug abuse remains a "chronic, persistent problem" in the United States with no simple solutions in sight in the opinion of a joint annual report by federal agencies involved with drugs. The report proposed no basic shift in federal policy toward drug abuse, but suggested the possibility of lifting or easing criminal penalties for smoking marijuana.

The Strategy Council on Drug Abuse declared the government "ought to strongly discourage the use" of marijuana. "The question, however, is how do we most effectively accomplish this with the least cost to society."

President Carter said during his campaign he favored decriminalization of possession of small amounts of the product, but he supported continued crackdowns on sale and distribution.

According to the report, marijuana carries a "relatively low social cost." Some 22 million Americans smoked marijuana last year, a "saturation" total that should prod the federal government into a decision on whether to continue to approach its use on a criminal basis.

The council is composed of the Drug Enforcement Administration (DEA), the National Institute on Drug Abuse, the State Department and the White House.

Malpractice Crisis Campaign Moves Ahead

MSMA's malpractice crisis public information campaign, which began with a series of statewide television spots in late December, entered its second phase in January with the mailing of a counter display and brochures about the malpractice crisis for distribution in Mississippi physicians' offices. The brochures have a tearoff card which can be sent to members of the Mississippi Legislature to urge support for legislation to ease the malpractice crisis.

The malpractice crisis public information campaign was approved by the MSMA House of Delegates at its 1976 annual meeting and is directed toward getting public support for remedial legislation which is before the 1977 Regular Session of the Mississippi Legislature. Information about the legislation has been sent to all MSMA members. The next phase of the public information campaign will consist of further spot announcements.

President Carter's Major Health Goals

(EDITOR'S NOTE—President Jimmy Carter outlined his major health goals in a speech before the American Public Health Association Convention during last year's presidential campaign. The following is a summary from that speech.)

First, we must basically focus on the prevention of illness and disease.

Second, we must have a comprehensive program of National Health Insurance. The coverage must be universal and mandatory. We must lower the present

barriers in insurance coverage and otherwise to preventive and primary care—and thus reduce the need for hospitalization. The rates for institutional care and physician services should be set in advance, prospectively. We should maintain the personal interrelationship between patients and their physicians and give freedom of choice in the selection of physicians and treatment centers. We must phase in the program as rapidly as revenues permit—catastrophic, prenatal and infant care should be among the highest priorities. Third, we must stress health and nutrition education.

Fourth, we must mount a renewed attack on cancer and other diseases caused by toxic chemicals in the environment.

It is not required that the government run the entire health care program in our country—I would not favor that.

Health Spending Reaches \$139 Billion

The Social Security Administration's newly published annual study "National Health Expenditures" shows the nation's total health bill amounting to \$139.3 billion in fiscal year 1976, an increase of \$17 billion or 14 per cent over 1975.

Public spending for health in 1976 reached almost \$59 billion, an increase of 15.6 per cent over 1975. On the other hand, spending by the private sector increased 12.8 per cent over 1975.

Hospital charges led in price increases, reaching 13.4 per cent over 1975. Physicians' charges rose 11.4 per cent over 1975. Preliminary SSA estimates of national health expenditures for fiscal 1976 are shown in the following chart.

In Billions—Source of Funds—1976

<i>Type of Expenditure</i>	<i>Total</i>	PRIVATE	PUBLIC
		TOTAL	TOTAL
Total	\$139,312	\$80,492	\$58,820
Health services and supplies	131,022	77,722	53,300
Hospital care	55,400	25,004	30,396
Physicians' services	26,350	19,718	6,632
Dentists' services	8,600	8,131	469
Other professional services	2,400	1,607	793
Drugs and drug sundries	11,168	10,144	1,023
Eyeglasses and appliances	1,980	1,866	114
Nursing-home care	10,600	4,744	5,856
Expenses for prepayment and administration	7,336	5,709	1,627
Government public health activities	3,255	—	3,255
Other health services	3,933	800	3,133
Research and medical-facilities	8,290	2,770	5,520
Research	3,327	258	3,069
Construction	4,963	2,512	2,451
Publicly owned facilities	1,673	—	1,673
Privately owned facilities	3,290	2,512	778



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IN CONCLUSION

Medical group practice has shown significant growth in the 1970s, according to the current edition of the AMA's Profile of Medical Practice. The information is compiled by the AMA's Center for Health Services Research and Development from the association's Physician Masterfile and the Periodic Survey of Physicians. The book shows there are 8,483 medical groups whose 66,842 physicians represent 23.5 per cent of the active nonfederal physician population.

A five-part medical education course on the history and diagnosis of and current concepts in clinical depression has been developed for primary care physicians and will use commercial television to maximize exposure and physician participation. "A Course on Clinical Depression" is sponsored by the Department of Psychiatry of the University of Pennsylvania under a grant from Pfizer Laboratories. Information will be mailed directly to primary care physicians nationwide.

Federal Communications Commission has unanimously rejected a petition backed by the attorneys general of 14 states to prohibit television advertising of over-the-counter drugs until after 9:00 p.m. FCC, in its 7-0 ruling, said it would not "accept the idea that otherwise lawful advertising should be prohibited...on the basis of mere speculation." Supporters of the ad restriction argued that repeated exposure of children to drug advertising would create a "pop-a-pill" society which condoned the misuse of illicit and licit drugs.

Six million U.S. workers suffer from noise-induced hearing losses, says a Stanford Research Institute researcher. He points out that workers in such noisy environments as printing presses, foundries and food processing plants risk losing the ability to discern crucial speech frequencies after 3 to 20 years. Many workers with such a hearing loss also suffer from tinnitus, and many are unable to benefit from any of the hearing aids available today. The cost to the worker is incalculable.

The first official trip to the U.S. by a delegation from the All-Russia Association of the Blind, sponsored by the American Foundation for the Blind, took place during December. Purpose of the trip was to exchange technical information on rehabilitation services, facilities and technical devices and help broaden knowledge in order to improve services for the blind, multiply handicapped and severely visually impaired persons in both countries. Jackson, Mississippi was one of six U.S. cities visited.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psycho-

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

ship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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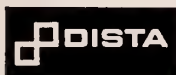
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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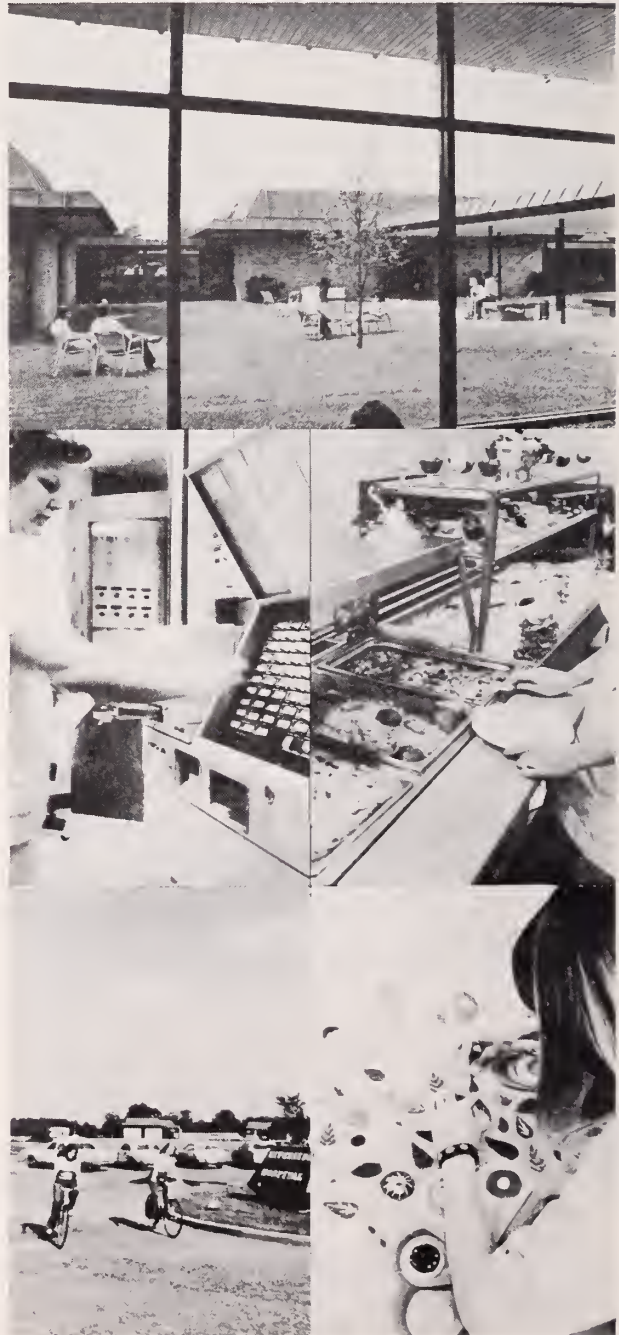
The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

For additional information contact: John R. Reedy, Executive Director.

Riverside Hospital

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Telephone: (601) 939-9030



Volume XVIII

Number 3

March 1977



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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$15.00 per annum; \$2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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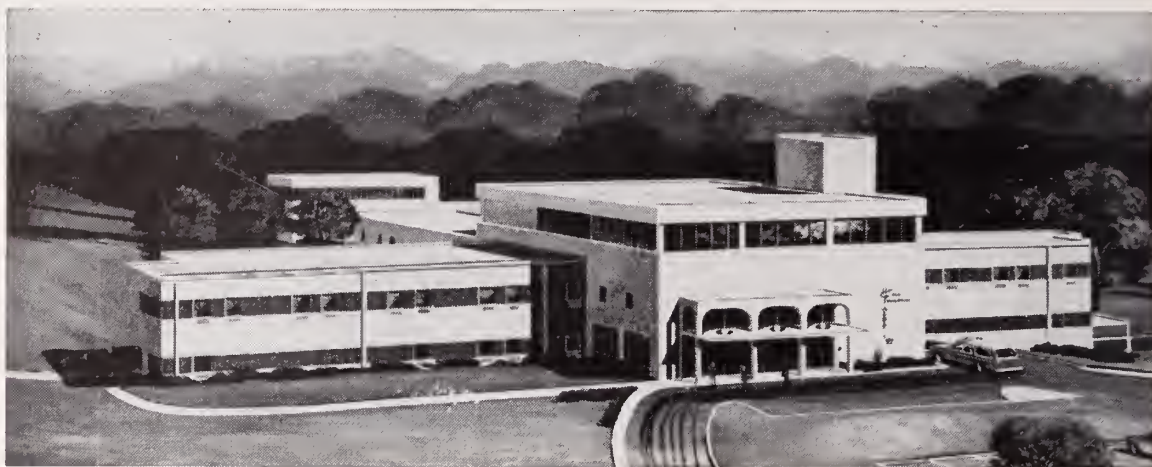
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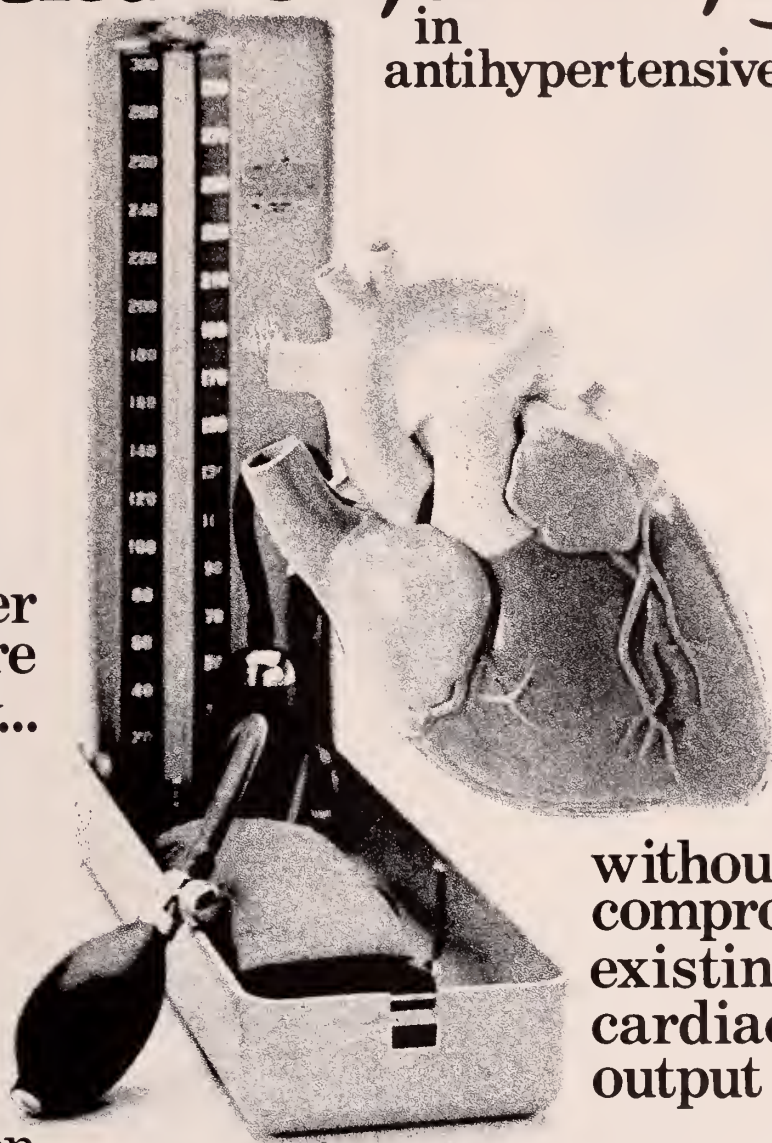
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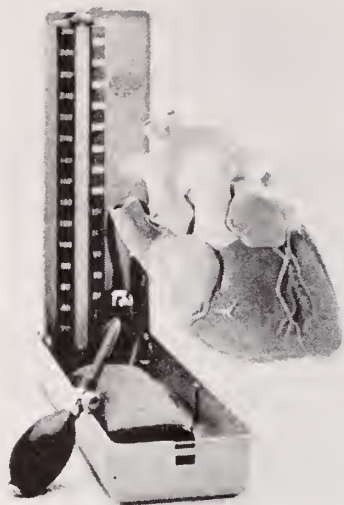
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Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyl dopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyl dopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyl dopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyl dopa. If a positive Coombs test develops during methyl dopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyl dopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyl dopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyl dopa, the drug should not be reinstituted. When methyl dopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyl dopa is stopped.

Should the need for transfusion arise in a patient receiving methyl dopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyl dopa. If caused by methyl dopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyl dopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyl dopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyl dopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyl dopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyl dopa because the drug is removed by this procedure.

Adverse Reactions: Central nervous system: Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyl dopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatulence, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyl dopa each, in bottles of 100; Tablets, containing 250 mg methyl dopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyl dopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07 (707)

MSD MERCK SHARP & DOHME

NEWSLETTER

March 1977

Dear Doctor:

The AMA rates high in public credibility, according to a recent Gallup poll. The poll tested the public's belief in communications of all types from government agencies, labor unions, and professional and trade associations. The AMA ranked 6.8 on a ten-point scale, while the average for professional associations was 6.5. The average rating for trade associations was 5.1, for government agencies 5.7, and for labor unions 5.4.

The public demonstrated its belief that AMA actions are in the public interest by giving the association a high 6.6 rating. This feeling of trust was supported in another Gallup poll in which 71% of the public said it had a great deal of or a fair amount of confidence in physician organizations.

The Federal Trade Commission has issued 48 subpoenas in its restraint of trade investigation of medical organizations. Included are 11 medical specialty boards and 37 specialty societies. Specialty boards subpoenaed are allergy and immunization, anesthesiology, family practice, internal medicine, nuclear medicine, otolaryngology, pathology, pediatrics, radiology, surgery and urology.

Sen. Herman Talmadge's (D-Ga) new Medicare-Medicaid Reform Act is expected to be ready within a month. The act, introduced during the last session of congress, is being expanded and strengthened. President Carter backed Talmadge's proposal but at the same time wanted it stronger. Bill provides incentives for cost savings. Talmadge is Senate Finance Health subcommittee chairman.

The House Commerce Health subcommittee will hold hearings late this year on the health planning act (Public Law 93-641) which expires in September. But first the committee will request a one-year extension of the act. Former Rep. James Hastings (R-NY), a major sponsor of the act, will serve 20 months to five years in prison for forcing two of his staffers to pay him some \$40,000 in kickbacks.

Dental insurance, high speed drills and dental assistants are mainly responsible for the 20% increase in patients seen by dentists compared to a decade ago, according to the Insurance Economics Survey newsletter. Dentists report treating at least a dozen patients a day and some schedule as many as 25 to 30. Average income for dentists is \$35,000, up from \$12,700 in 1965.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Think you know all about asthma?

Then you should know all about TEDRAL.

It provides —

- ☐ rapid symptomatic relief, as well as prophylaxis
- ☐ β -ADRENERGIC ACTION THAT RELAXES BRONCHIAL SMOOTH MUSCLE
- ☐ α -ADRENERGIC ACTION THAT REDUCES BRONCHIAL EDEMA AND SECRETIONS
- ☐ synergistic action of ephedrine and theophylline for effective and prolonged bronchodilation
- ☐ dosage forms to meet individual patient needs

For asthma management...

Tedral®/Tedral SA®/Tedral Elixir

Each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer), 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); and 25 mg phenobarbital in the immediate release layer

Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

SUSTAINED ACTION



WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

T-GP-74-B/W

CAUTION: Federal law prohibits dispensing Tedral SA without prescription.

Description. Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Tedral SA: each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital in the immediate release layer.

Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

Tedral Elixir is convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients; porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: **Note:** One teaspoonful is equivalent to *one-quarter* Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

STORE BETWEEN 59° and 86°F (15° and 30°C).

Full information is available on request.

Health Insurance Study Released

A recently released Congressional Budget Office Study reports that serious health insurance coverage problems exist for the health care expenses incurred by low-income families.

The study estimated that 40 million persons having less than \$10,000 income are either uninsured or not eligible for Medicaid, or hold non-group insurance policies whose coverage "is generally very poor."

While the study contained no recommendations, it did outline three types of catastrophic protection options designed for federal financing;

- A traditional insurance plan to supplement Medicare and average private insurance coverage. If totally tax financed, such a plan could result in net increases in federal health expenditures estimated at about \$12 billion in fiscal year 1978, the report said.
- A plan to pay all out-of-pocket medical expenses (excluding long-term care costs) that exceed 15 per cent of family income. Such a plan is estimated to increase federal health expenditures by approximately \$12.5 billion in fiscal year 1978.
- A plan to federalize the Medicaid program, improve Medicare benefits, and create tax incentives for improved private catastrophic coverage. The estimated increase in federal expenditures generated by such a plan in fiscal year 1978 is \$20 billion to \$21 billion.

Southeastern Surgical Congress Meets

Some 2,000 surgeons, specialized nurses and other members of the medical profession are expected to attend the 45th anniversary assembly of the Southeastern Surgical Congress, April 3-7, at the Americana Hotel, Bal Harbour, Miami Beach.

More than 50 lectures plus technical and scientific exhibits and informal discussions are scheduled.

Both the scientific sessions and postgraduate course are accredited by the American Medical Association for Category I credit.

For more information, write the congress office, 315 Boulevard, N.E., Atlanta, GA 30312.

consider the effect on coexisting diabetes when you prescribe a vasodilator*



(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the diabetic patient has been reported with

VASODILAN® (ISOXSUPRINE HCl) the compatible vasodilator

TABLETS, 20 mg.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

Mead Johnson LABORATORIES

DATELINE

Ineligible People Washington, DC - Some \$109 million in food stamps was
Get Food Stamps given to 725,000 ineligible recipients in the first six
 months of 1976, reports the U.S. Department of Agriculture.
Plus, about \$105 million in food stamp overpayments went to 1.8 million people.
Added to the \$225 million improperly paid in the previous six months, these figures
show that the Food Stamp fraud and administrative error approaches the half billion
dollar level per year.

Dental Association Washington, DC - American Dental Association was charged
Prevents Competition with preventing competition by not allowing dentists to
 advertise fees as Federal Trade Commission expanded its
investigation of medical and health organizations. ADA issued a statement saying
it "has neither fostered any practices nor engaged in any conduct relating to its
advertising ethics which is in violation of the Federal Trade Commission Act."
FTC announced it's beginning an investigation of entire dental care industry.

Hospital Staffs Chicago, IL - "Hospital Medical Staff Advocate," a new AMA
Get Guidelines newsletter for hospital medical staffs, is being mailed to
 7,000 hospitals and to executive secretaries of state,
local and metropolitan medical societies. The objective of the newsletter, which
will appear five times a year, is to provide medical staff with current and
pertinent information, to announce AMA activities of interest to them specifically,
and to serve as a line of communication among staffs around the country.

Maternity Sick Pay Washington, DC - In a split six to three decision, the
Is Not Mandatory Supreme Court ruled that excluding pregnancy from a dis-
 ability plan by an employer does not violate Title VII of
the Civil Rights Act of 1964. "We do not therefore infer that the exclusion of
pregnancy disability from the (GE) plan is a simple pretext for discrimination
against women," wrote Justice Rehnquist, explaining that the GE plan "is nothing
more than an insurance package which covers some risks, but excludes others."

"If You Drink,
Don't Drug" Dallas TX - That was the central message of a month-long
 campaign sponsored by the Dallas Council on Alcoholism
 in cooperation with the Dallas County Pharmaceutical
Society to alert the public about the dangers of alcohol and drug interaction.
This message, with an explanation of the dangers, was printed on 4 x 5-inch cards
and mailed to 1,850 physicians for distribution with appropriate prescriptions.
Also, posters were displayed in Dallas pharmacies and drug stores.



Tolinase[®]

tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

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AMA Expands Continuing Medical Education Opportunities in 1977.



Now you can choose from 15 regional CME meetings!

Recognizing the importance of continuing medical education to its members, the AMA has greatly expanded its CME programs. During 1977, the AMA will offer 15 regional CME meetings around the country in addition to its scientific programs at both the Annual Convention and Winter Meeting.

The purpose of the regional programs is to make it easier and more convenient for you to continue your medical education by bringing the meetings closer to your hometown and by scheduling them on the weekends to

avoid interference with your practice.

All courses are approved by the AMA Council on Continuing Physician Education for Category 1 credit toward an AMA Physician's Recognition Award. A syllabi written by medical school faculties is provided with every course.

Specific information on course location, fees, academic program, faculty, and hotel reservations will be available approximately 2 months before each course date. Please write to address below at that time stating your selection(s). Print name, address, and office phone number.

1977 Regional Schedule

Tulsa, Oklahoma	January 22-23
Birmingham, Alabama	February 5-6
*Lake Tahoe, Nevada	February 11-13
Denver, Colorado	February 19-20
*Tarpon Springs, Florida	March 4-6
Detroit (Southfield), Michigan	March 26-27
New York (Westchester), New York	April 16-17
Houston, Texas	May 15
Hartford, Connecticut	September 10-11
*Lake of the Ozarks, Missouri	September 16-18
Chicago, Illinois	September 24-25
*Hot Springs (Homestead), Virginia	Sept. 30-Oct. 2
*Huron, Ohio	October 7-9

*Honolulu, Hawaii	Oct. 30-Nov. 4
Hershey, Pennsylvania	November 18-19

AMA's 126th Annual Convention

San Francisco, California	June 18-22
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AMA's Winter Scientific Meeting

Miami Beach, Florida	December 10-13
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AMA Spokesmanship Seminars

Chicago, Illinois	August 13-14
(Marriott O'Hare Hotel)	November 12-13

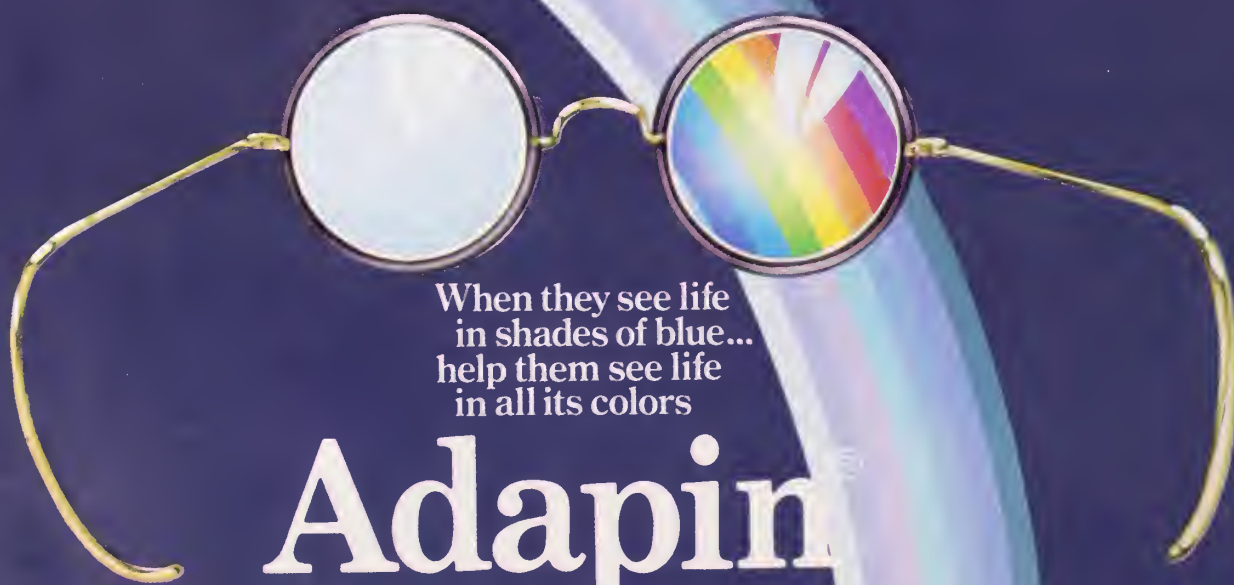
*Courses end at midday for recreation activities

AMA Department of Meeting Services
535 North Dearborn Street
Chicago, Illinois 60610

Depression comes in
shades of blue



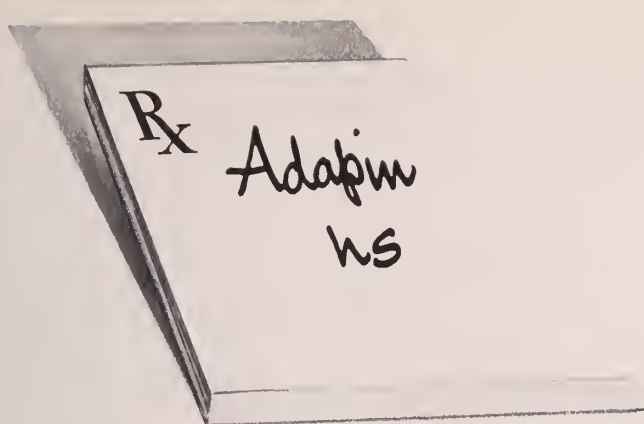
Insomnia
is a shade of blue
that often accompanies
depression



When they see life
in shades of blue...
help them see life
in all its colors

Adapin[®]
(doxepin HCl)

Please see prescribing information on the right-hand page



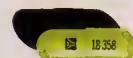
Available as



10-mg. capsules



25-mg. capsules



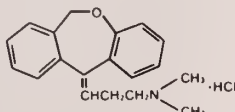
50-mg. capsules

ADAPIN® (Doxepin HCl)

Prescribing information:

DESCRIPTION

Adapin (doxepin HCl) is an isomeric mixture of N, N-dimethyl-dibenz(b,e) oxepin- $\Delta^{11}(6H)$, γ propylamine hydrochloride.



ACTIONS

Adapin has a variety of pharmacological actions with its predominant action on the central nervous system. While its mechanism of action is not known, studies have demonstrated that it is neither a monoamine oxidase inhibitor nor a primary stimulant of the central nervous system.

INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin**.

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—Adapin has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin (doxepin hydrochloride)**, gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin**. The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin**; therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression:

10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

Each capsule contains doxepin, as the hydrochloride, 10 mg. (NDC 0018-0356), 25 mg. (NDC 0018-0357), and 50 mg. (NDC 0018-0358) capsules in bottles of 100 and 1000.



Penwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603



RECENT CHANGES

federal register

Providing
Drug Information
to Physicians

Informational
Bulletin #433-76

**National
Health
Insurance**

special report
**Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
'MAC' rules**

**Drug
Substitution**

The 4 corners: A new era in
of Health Practice
RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Many Women Abandon the Pill

Adverse publicity about oral contraception in recent years may be leading to a striking movement away from the pill and back to either mechanical barrier methods or no protection at all against pregnancy.

A study of 100 women patients at the outpatient unit of the University of California at San Francisco Medical Center revealed that 53 per cent of the women had changed contraception methods in the last two years, most commonly moving away from oral contraception, the report says.

Sixteen of the women in the study said they were using no contraception. One woman relied on the rhythm method, and 24 used a mechanical barrier (diaphragm, foam, or condom). Only 28 women were using oral contraceptives, while 16 had an intrauterine device in place. Eight relied on sterilization. Fourteen of the women were dissatisfied with their current method of contraception, usually because of possible hazardous side effects.

The study sought to determine current attitudes toward reproductive and sexual roles. Major areas of change apparent in the younger population were

a substantial decrease in formal marriage, a reduction in the wish for children, a movement away from oral contraception and back to mechanical barrier methods, and a shift toward acceptance of a bisexual adaptation, report Susan Wall, R.N., and Nancy Kaltreider, M.D.

A high percentage of nonmarital cohabitation (23 per cent) and single living (17 per cent) marks a new adherence to alternate lifestyles, they report. Some 37 per cent of heterosexual women said they considered a homosexual relationship to be a future possibility.

Cancer Society Attacks FDA

The American Cancer Society has urged Congress to remove control for the testing of new anti-cancer drugs from the Food and Drug Administration and place it in the National Cancer Institute.

The society's action is the latest development in a growing controversy between some of the country's outstanding cancer researchers and the FDA. The researchers claim that the FDA needlessly delays approving drugs for clinical use in human patients because of an overcautious concern about safety in the cancer patient.

Is there a tablet containing only
an expectorant and only
Glyceryl Guaiacolate? **YES!**

1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
4. Sugar-free tablet.

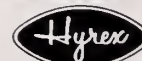
An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS

(GLYCERYL GUAIACOLATE 100mg.)

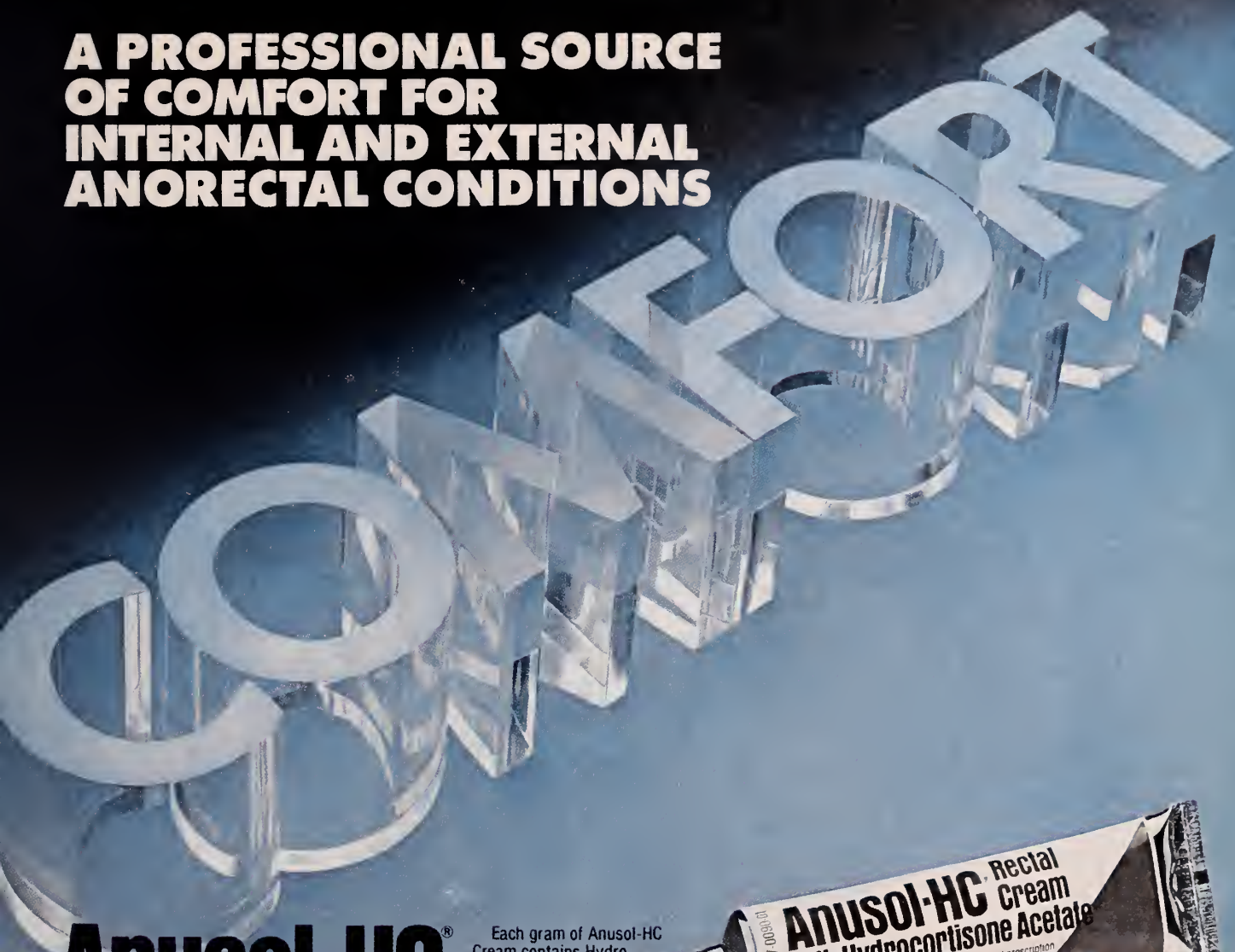
Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. **HOW SUPPLIED:** White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.



HYREX COMPANY
832 South Cooper
Memphis, Tenn. 38104

A PROFESSIONAL SOURCE OF COMFORT FOR INTERNAL AND EXTERNAL ANORECTAL CONDITIONS



Anusol-HC[®]

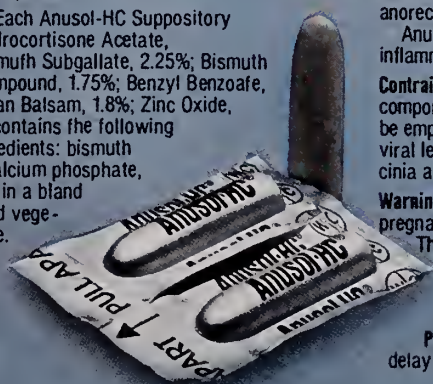
suppositories and cream with
hydrocortisone acetate. Rx only
**pain and burning
respond in minutes**

ANUSOL-HC[®] SUPPOSITORIES
Rectal Suppositories with Hydrocortisone Acetate

ANUSOL-HC[®] CREAM
Rectal Cream with Hydrocortisone Acetate

CAUTION: Federal law prohibits dispensing
without prescription.

Description: Each Anusol-HC Suppository
contains Hydrocortisone Acetate,
10.0 mg; Bismuth Subgallate, 2.25%; Bismuth
Resorcin Compound, 1.75%; Benzyl Benzoate,
1.2%; Peruvian Balsam, 1.8%; Zinc Oxide,
11.0%; also contains the following
inactive ingredients: bismuth
subiodide, calcium phosphate,
and coloring in a bland
hydrogenated vege-
table oil base.



Each gram of Anusol-HC
Cream contains Hydro-
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Peruvian Balsam, 18.0 mg; Zinc Oxide, 110.0 mg;
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propylene glycol, bismuth subiodide, propyl-
paraben, methylparaben, polysorbate 60, sorbi-
tanol monostearate in a water-miscible base of
mineral oil and glyceryl monostearate.
Nonstaining.

Indications: Anusol-HC is adjunctive therapy for
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in: external and internal hemorrhoids, proctitis,
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anorectal surgery.

Anusol-HC is especially indicated when
inflammation is present.

Contraindications: History of sensitivity to any
component. Topical corticosteroids should not
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viral lesions of the skin (including herpes, vac-
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Warning: The safe use of topical steroids during
pregnancy has not been fully established.
Therefore, during pregnancy they should
not be used unnecessarily on exten-
sive areas, in large amounts or for
prolonged periods of time.

Precautions: Symptomatic relief should not
delay definitive diagnoses or treatment. When



there is bacterial skin infection, topical cortico-
steroids should be used only with appropriate
concomitant antimicrobial therapy. Prolonged
or excessive use of corticosteroids might pro-
duce systemic effects.

Dosage and Administration: Anusol-HC Supposi-
tories: Remove foil wrapper and insert supposi-
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morning and at bedtime, for 3 to 6 days or until
inflammation subsides. Then maintain patient
comfort with regular Anusol.

Anusol-HC Cream: Adults—After gentle bath-
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tor and insert into the anus by applying gentle
continuous pressure. Then squeeze the tube to
deliver medication. Cream should be applied 3
or 4 times a day for 3 to 6 days until inflama-
tion subsides.

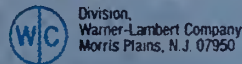
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ORIGINAL PAPERS

A Rational Approach to Early Breast Cancer

WILLIAM B. O'KELLY, M.D.

Weir, Mississippi

FOR THOSE OF US concerned with the actualities of day to day primary care, it has long been axiomatic that by the time a diagnosis of carcinoma of the breast is made in the premenopausal female she is doomed. There are exceptions to this, of course. Serendipitous discovery of a breast mass on a routine physical prior to the patient's discovery of same is, of course, associated with a better prognosis.

Twenty per cent or more patients with primary operable carcinomas of the breast with axillary nodal metastases have occult bone metastases at the time of initial evaluation as detected by bone scans despite lack of symptoms. Also, death from cancer of the breast occurs as a result of vital organ involvement almost without exception. Local disease and/or nodal metastases virtually never causes death.¹

Deaths from cancer of the breast whether pre- or postmenopausal are frequent in the first two years after discovery but others are sufficiently delayed so that only 60 per cent of eventual cancer mortality is found at the end of five years and only 80 per cent by 10 years. This delayed mortality curve never becomes horizontal, in contrast to that of other common cancers.¹

The majority of patients do not have local or axillary recurrence when the disease is first found to be metastatic; i.e. metastases is not a failure of surgery per se but a reactivation of tumor cells which have remained quiescent in the interim.¹

Concrete decrease in the mortality and morbidity rates must deal with the control of these micrometastases.

Difficulties in making earlier, more precise diagnosis include: 1) patient not performing self-examination; 2) lack of an adequate screening program (mammography, thermography and xeroradiography

have thus far proved impractical for one reason or another); 3) technical difficulties in the more dense premenopausal breast in the patient with questionable mass; 4) inavailability of xeroradiography and thermography to the greater mass of patients with the current state of the art; 5) delay in seeking physician's aid.^{2, 3, 4, 15}

The author discusses the current status of carcinoma of the breast occurring in the premenopausal female and points out that significant decrease in the mortality and morbidity rates must come from control of micrometastases. He says excision of primary tumor should be followed by adjuvant chemotherapy, possible immunotherapy and hormonal treatment and also discusses the problems of nutrition, depression and nosocomial infections in these cancer patients.

Once the patient seeks the aid of the physician, diagnosis must include adequate history and physical, and mammography of any breast mass. Finite diagnosis is possible only through surgical means.

Once biopsy of a lesion has determined the presence of a carcinoma, excision should be attempted. The pros and cons of radical vs. simple mastectomy will not be entered here but it is felt that the primary burden must be removed.⁵ My own personal opinion is that the modified radical is to be preferred over the more mutilating procedures. Axillary dissection must be done for the pathological information contained in nodal involvement.

Studies in progress at Baylor and elsewhere seem to show promise as to delineation of the role of hormones and their receptors in carcinomatous patients.^{6, 7, 14} Until this work is finished however, and

Practicing family physician, Weir, MS.

practical laboratory procedures for detection of hormone receptors are established, one is forced to utilize hormonal manipulation in the patient who already has developed metastatic recurrence.⁷ With the increased mortality attendant to premenopausal breast carcinoma, it has been felt that some type of ovarian ablation should be attempted. There is no evidence however, that prophylactic oophorectomy favorably influences survival or recurrence rates.¹¹

Postoperative irradiation has been the custom for many years. It is not proper, however, to utilize irradiation simply because the attending physician feels most comfortable with this modality being administered.¹¹ Studies by NSABP (National Surgical Adjuvant Breast Project) failed to show any advantage to adjuvant administration of irradiation. In a study involving 1100 patients (at the end of five years) 50.6 per cent of patients receiving radiation therapy were free of disease whereas 50.2 per cent of controls were free of disease.¹¹

Work published in *JAMA* in February 1976 indicates also that the leukopenia which follows mastectomy irradiation in 75 per cent of patients may persist for several years. This should serve to effectively deny adjuvant chemotherapy to three-quarters of irradiated patients for varying periods of time.¹²

Initial work in the administration of adjuvant chemotherapy was not very promising. Administration of thiotepea on the day of and for two days following mastectomy showed only a delay in onset of recurrence in premenopausal patients having four or more positive nodes. Adjuvant administration of 5-fluorouracil produced similar results.^{11, 13}

Prolonged administration of 1-PAM (phenylalanine mustard) had better results. Treatment failure occurred in 30 per cent of premenopausal patients receiving placebo and in 3 per cent of treated patients at the end of two years.¹³

Other ongoing studies involve 1-PAM and 5-fluorouracil.¹³

According to the *New England Journal of Medicine* article by Bonadonna et al, a combination adjuvant chemotherapy utilizing Cytosan, methotrexate and 5-fluorouracil (CMF) appears to offer a clear-cut advantage. Heretofore those patients with nodal metastases have been clearly associated with the highest risk. Of particular importance to me was the difference between percentage of treatment failures in control and treated groups of patients having four or more axillary nodes involved (40.7 per cent failures in the control group and 8.8 per cent in the treated group).^{16, 17}

Also reviewed in this article was incidence of side

effects and acceptability of these as a risk in informed consent given by patients.

Combination chemotherapy utilizes cytoxan (alkylating agent) to destroy resting tumor cells so that replication of others would make them more amenable to destruction by methotrexate and 5-fluorouracil (cytologically active agents).⁹ It is of interest to note that thus far vincristine seems to add nothing to the program.

Mathe and coworkers feel that in childhood leukemias immunotherapy will remove vestigial cell remnants once the total cell population has been decreased below 1×10^6 by chemotherapy. Whether or not such a premise will carry over into other fields of oncology has not been determined.¹⁰

Other factors influencing morbidity and mortality are nutrition and nosocomial infections. The author feels that home treatment whenever possible will help control these two factors. Cachexia in malignant patients is widespread. Some is attributable to the primary illness, some to the stigmata of the disease and some to hospital food. Any factors which might influence this favorably should be utilized. Most of us have seen cancer patients who have starved themselves either consciously or unconsciously to terminate their disease.

The stigmata of oncological disease including acute and chronic depression should be treated actively and prophylactically. The possibility that their family physician could keep them at home and treat them with 1976 methods to extend their lifetime and improve the quality of that life by decreasing morbidity and prevention of pain should be discussed.¹⁸

The problems of nosocomial infections are familiar to all of us and will not be discussed here. It might be added that if the patient is treated at home the chances will be improved that any infectious process will be one which can be effectively treated.

SUMMARY

Carcinoma of the breast in the premenopausal patient is a complex disease requiring the evaluation of many factors by the family physician, radiologist, surgeon and oncologist in order to improve the quality and quantity of life.

All possible modalities of diagnosis should be utilized and further efforts are needed to develop adequate screening methods.

Excision of primary tumor should be followed by adjuvant chemotherapy, possible immunotherapy and hormonal treatment. Radiotherapy should be reserved for treatment of local recurrence and skeletal metastases.⁸

★★★

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The author will furnish a list of references on request.

Rabies in Mississippi

KENNETH E. POWELL, M.D.,¹ RICHARD H. ANDREWS,²
PETE FUSSELL,³ and DURWARD L. BLAKEY, M.D.⁴
Jackson, Mississippi

RABIES in humans, with one well-documented exception, is a fatal illness.¹ Fortunately the administration of human rabies hyperimmune globulin (HRIG) and duck embryo vaccine (DEV) following a bite by a rabid animal (post-exposure prophylaxis) usually prevents the development of clinical disease. However, most animal bites are not inflicted by rabid animals. Prophylaxis should never be given to anyone in whom the risk of clinical rabies is less than the risk of side effects from the prophylaxis. The following discussion of rabies in Mississippi is intended to assist Mississippi physicians in deciding when to administer post-exposure prophylaxis.

RABIES IN MISSISSIPPI ANIMALS

The bat is the only animal in Mississippi known to have had rabies after 1961, the year in which the last reported case of canine rabies occurred. Table 1 shows that during the past 10 years the proportion of bats identified as positive for rabies virus by the Bureau of Public Health Laboratories, Mississippi State Board of Health, has remained nearly constant at 10 per cent even though the number of bats examined has decreased. The rabid bats have come from all parts of the state (see Figure 1). The greater number of rabies positive bats from certain districts reflects a larger number of specimens submitted rather than a higher prevalence of rabid bats.

During the past 10 years, the state laboratory has examined 7,854 animals for rabies and found rabies in no animal except the bat (see Table 2). In states adjacent to Mississippi, foxes, skunks, dogs, and other animals in addition to bats harbor the rabies virus (see Table 3). Throughout the United States, rabies is most often found in skunks, foxes, and bats.

Rabies in racoons is common in Florida and Georgia. Rabies in dogs is now relatively uncommon.

Physicians caring for patients with animal bites need to consider the species of animal involved and the circumstances of the bite before administering post-exposure rabies prophylaxis. In Mississippi the bat is the only animal known to be infected with rabies. In adjacent states foxes and skunks are known to carry rabies. Rodent bites rarely, if ever, justify prophylaxis. Post-exposure prophylaxis includes local wound care and administration of human rabies immune globulin and duck embryo vaccine.

MISSISSIPPI VACCINATION PROGRAM

Existing state law requires that dogs be immunized with an approved antirabies vaccine at six months of age and yearly thereafter. Enforcement of the law varies from county to county. No current data are available showing the number of dogs vaccinated annually or the proportion of dogs adequately vaccinated.

HUMAN EXPOSURE MANAGEMENT

In the case of an animal bite, examination of the brain of the offending animal by a reliable laboratory provides the best information for or against the diagnosis of rabies. The Mississippi State Board of Health Laboratory examines the brain of all animals except bats by staining sections with Sellar's stain to detect Negri bodies and of all animals including bats with the fluorescent antibody (FA) test for rabies virus. The Sellar's stain is completed within four hours after receipt of the specimen. Negri bodies are seen in 85-95 per cent of animals with rabies.³ The FA test requires about five hours, is done every other day, and has 99 per cent or higher agreement

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with the mouse inoculation test which has been the standard test for rabies virus activity. The state laboratory does not perform the mouse inoculation test because it requires 7-28 days for completion and presently has little to offer over a properly performed FA test.⁴

The natural course of rabies in wild animals is too unpredictable to justify observation; thus, the wild animal that has bitten a human and may be rabid should be killed and decapitated as soon as possible. Care should be taken not to shoot or otherwise mutilate the animal's head because this precludes laboratory evaluation. The local health department has suitable shipping containers and can assist with the transportation of the specimen to the laboratory. The unamutilated head should be placed in a plastic bag, and then into a metal can. It should be refrigerated (not frozen) if not shipped immediately. The metal can and a refrigerant should be placed in a suitable shipping container and transported to the state laboratory. A telephone call to the State Board of Health prior to shipping the specimen facilitates its management in the laboratory.

Dogs and cats may be observed for 10 days after biting a human. If the animal remains well, rabies is ruled out. If the animal shows signs of illness or dies during the observation period, the animal's head should be submitted to the lab as described above. Stray or unclaimed dogs and cats may be observed for 10 days or sacrificed immediately. Previously, it was recommended that all dogs and cats be observed 10 days or until the onset of symptoms because Negri bodies are more easily seen in the brains of

symptomatic animals; however, the WHO Expert Committee states that the sensitivity of the FA test is sufficient for diagnosis without the observation period.⁵

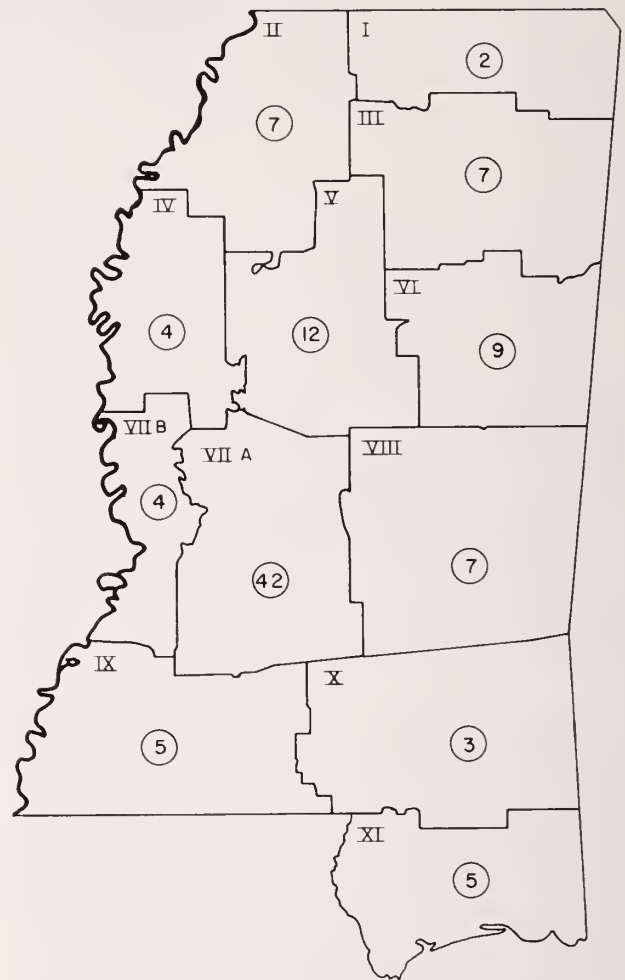


Figure 1. Number and location of rabid bats, identified by the Bureau of Public Health Laboratories, Mississippi State Board of Health, 1966-1975.

TABLE 1
NUMBER OF BATS TESTED AND NUMBER
OF BATS POSITIVE FOR RABIES VIRUS,
MISSISSIPPI, 1966-1975

Year	Number Tested	Number Positive	Percent Positive
1966	414	39	9
1967	223	25	11
1968	107	12	11
1969	62	9	15
1970	55	5	9
1971	26	2	8
1972	52	7	13
1973	61	4	7
1974	35	2	6
1975	50	3	6
Total	1085	108	10

Frequently, the offending animal is not caught, is thoughtlessly killed and buried, or escapes, and the decision regarding prophylaxis must be made without the benefit of either observation or laboratory examination. The management of this problem has been reviewed by Corey and Hattwick.⁶

Unnecessary prophylaxis is the rule rather than the exception and, in many instances, the risk from the treatment is greater than the risk of the disease. There is no easy way for the attending physician to escape responsibility for the decision to begin prophylaxis or not. Keeping this in mind, together with the knowledge of the animals that have rabies in Mississippi and adjacent states, a few generalizations can be made:

1. In our opinion, no patient should be started on prophylaxis during the 10-day watch period because vaccine anaphylaxis usually occurs in the first five days of therapy. If the physician feels strongly that prophylaxis should be started before the completion of the 10-day observation period, the dog or cat should be sacrificed and examined immediately rather than expose the bitten person to unnecessary prophylaxis.
2. If the person was not bitten or was not licked on an open wound or mucous membrane, prophylaxis is not indicated.
3. If rabies is not known or suspected in the species of animal which has inflicted the wound in the geographic area in which the animal is located, prophylaxis is not indicated. In Mississippi, bites by bats require prophylaxis because rabies is known to affect about 10 per cent of examined bats. Bites by wild foxes and skunks often require prophylaxis because these species have been shown to have rabies in adjacent states. Dog bites rarely justify prophylaxis because there has been no rabies in dogs in Mississippi for over a decade.
4. Rodents rarely are rabid and have not been shown to transmit rabies to humans. Bites by rats, mice, chipmunks, squirrels, rabbits, or other rodents, rarely, if ever, justify prophylaxis. Only wild or recently captured rodents which exhibit grossly abnormal behavior (aggressiveness or paralysis) should be examined for rabies. The Florida State Board of Health examined 20,000 rodents for rabies between 1954 and 1974, and only one was positive.⁷
5. Bites inflicted by an animal struck by a car, wounded by a hunter, or otherwise harassed by its victim probably do not justify prophylaxis.

TABLE 2

NUMBER OF ANIMALS TESTED FOR RABIES BY SPECIES, MISSISSIPPI, 1966-1975

<i>Animal</i>	<i>Numbers</i>
Dogs	2562
Cats	1780
Bats	1085
Squirrels	676
Rat	511
Foxes	276
Hamsters	258
All others	706
Total	7854

POST-EXPOSURE PROPHYLAXIS

Any animal bite demands early, thorough local treatment. The wound should be thoroughly cleansed with copious amounts of soap and water. It should be rinsed free of soap (since soap inactivates quaternary ammonium compounds) and then rinsed with a quaternary ammonium compound such as 1 per cent benzalkonium chloride. This cleansing procedure alone significantly reduces the risk of rabies.

TABLE 3

AVERAGE ANNUAL NUMBER OF CASES OF RABIES IN ANIMALS IN FIVE SOUTHEASTERN STATES, 1970-1974²

<i>State</i>	<i>Dog</i>	<i>Bat</i>	<i>Fox</i>	<i>Skunk</i>	<i>Other</i>	<i>Total</i>
Alabama	4	3	35	3	13	58
Arkansas	3	6	5	59	15	88
Louisiana	8	5	27	7	4	51
Mississippi	0	4	0	0	0	4
Tennessee	8	10	49	46	25	138

If the animal is proven to have rabies, or if the animal cannot be examined and the attending physician decides rabies prophylaxis is indicated, the following steps are appropriate:

1. Human rabies immune globulin (HRIG) is now available commercially and, in spite of higher cost, should be administered instead of equine antirabies serum (ARS). HRIG is indicated regardless of the length of time between the animal bite and the decision to administer prophylaxis. The dose of HRIG is 20 IU (international units)/kg; one-half the dose is given intramuscularly and one-half is infiltrated about the wound. The virus has been shown to remain at or near the site of introduction for up to two weeks. HRIG presently costs about \$35.00 per 2-ml vial (300 IU).
2. Duck embryo vaccine (DEV) should be started the same day that HRIG is given. A total of 23 doses (1 ml/dose) is required. It may be given 1 ml per day for 21 days, with 1 ml boosters on days 31 and 41; or, it may be given 2 ml per day for days 1-7 and 1 ml per day for days 8-14, with 1 ml booster doses on days 24 and 34. Local reactions (pain and erythema) occur in nearly 100 per cent of patients. Systemic reactions such as fever, malaise, or myalgias occur in 33 per cent. Anaphylaxis usually occurs in association with 1 of the first 5 doses and occurs in about 0.5 per cent of recipients.⁸ Severe reactions such

as transverse myelitis, neuropathy, or encephalopathy were reported in 13 of the approximately 434,000 persons who received this vaccine between 1958 and 1971, for a rate of about 0.003 per cent.⁶

3. At the time of either the first or second booster, all persons receiving duck embryo vaccine (DEV) should have serum drawn for rabies antibody determination. The serum, accompanied by a report showing the age, race, sex, and body weight of the patient, dose of HRIG, and dose schedule of vaccine, should be sent to the State Board of Health Laboratory. Additional vaccine is indicated for persons with a serum neutralizing (SN) antibody titer $< 1 : 5$.⁹ If an immunized person with previously documented SN antibody is bitten by a rabid animal only 5 daily doses (1 ml) of vaccine and a 1 ml booster at 20 days are required.
4. The use of systemic steroids interferes with antibody formation and should be avoided during administration of duck embryo vaccine. ★★★

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Maternal Mortality in Mississippi: 1973-74

WILLIAM B. WIENER, M.D.

Jackson, Mississippi

IN 1957, THE Mississippi State Medical Association (MSMA) established a committee to survey and study as a continuing research and educational program, the maternal mortality cases occurring each year in the state of Mississippi. The Committee on Maternal and Child Care has recently completed its study data for the calendar year 1973-1974.

Death certificates from the Mississippi State Board of Health furnished to the committee indicates that there were 11 and 13 maternal deaths in Mississippi in 1973 and 1974, respectively. The number of live births totalled 44,139 in 1973 and 44,032 in 1974, thus continuing a downward trend in live births begun in 1972 and probably reflective of a number of sociological factors to include an increase in sterilizations and terminations of pregnancies.

The maternal mortality rate in Mississippi (maternal deaths per 10,000 live births) was 2.5 in 1973 and 3.0 in 1974. This was a considerable improvement over the 1971 and 1972 death rates which were 4.3 and 5.2 respectively and continued an overall downward trend in the maternal mortality rate in Mississippi, which was 12.0 in the first year of the committee's study. The maternal mortality rate for the United States in 1973 was 1.3. Data for 1974 was not available at the time this article was prepared.

Techniques of obtaining and reviewing information on maternal deaths have not changed appreciably during the 18 years of study. The questionnaire type of inquiry has been exclusively employed. No "on the spot" investigations of hospital records or interviews of physicians or hospital personnel have been conducted except under rare circumstances involving hospitals in Jackson. The data sheet used was developed by the committee before

the study began and has undergone only minor changes since then. One of the data sheets, together with a letter from the chairman of the committee, is sent to the physician who last attended the patient. He or she is asked to complete and return the data sheet and add any pertinent information in a supplementary note. If the physician does not reply, two follow-up letters are sent at appropriate intervals. In some cases, personal attempts have been made by members of the committee, the State Board of Health, officers of the association, or local obstetricians to obtain information. Letters requesting additional information have occasionally been sent to the responding physician by the committee, if it seemed likely that he could supply further information which might be of value.

A summary of data obtained by the MSMA Committee on Maternal and Child Care from its study of maternal deaths in Mississippi in 1973-74 is presented. The author, chairman of the committee, reviews the committee's methods of study and the results found.

Following receipt of the data sheet and other information, all identifying marks are removed so that anonymity is preserved. A copy of the data sheet is then sent to a member of the committee for review prior to the next meeting. At the quarterly meeting of the committee the case is summarized by the member who has studied and evaluated it according to the criteria set out in the AMA "Guide for Maternal Death Studies." The evaluations are discussed by the committee, agreed to or voted on if there is a division of opinion, and then furnished to the attending physician.

The committee studied 17 maternal deaths occurring in 1973 and 1974. All replies to the committee's inquiries are evaluated as to their usability (see Table I) and usable replies are classified according to the adequacy of the data furnished (see Table II). In order to receive the highest rating,

Chairman, Committee on Maternal and Child Care.

Committee members—W. W. Walley, M.D., Waynesboro; W. E. Godfrey, M.D., Natchez; George J. Nassar, M.D., Greenwood; K. Ramsay O'Neal, M.D., Hattiesburg; Wendell H. Stockton, M.D., Amory.

Consultants—Catherine G. Goetz, M.D., Jackson (Pathology); Alvin E. Brent, Jr., M.D., Jackson (Internal Medicine); Curtis W. Caine, M.D., Jackson (Anesthesiology).

MATERNAL MORTALITY / Wiener

which is 5, the questionnaire for the committee's study must be completely filled out, a relevant explanatory note attached and an autopsy report included if available. Cases rated 1 or 2 are often difficult to evaluate because of the scanty nature of the data received.

Following the AMA "Guide for Maternal Death Studies," the committee classifies maternal deaths as either being direct obstetric deaths or indirect obstetric deaths. Direct obstetric deaths are defined by the Guide as those in which the cause of death is due to a condition directly related to the pregnancy such as hemorrhage, toxemia, infection, anesthesia, or vascular disease. Indirect obstetric deaths are those resulting from disease present before or developing during pregnancy which was not a direct effect of the pregnancy but was obviously aggravated by the physiological effects of the pregnancy and caused the death. Classification of maternal deaths studied by the committee in 1973 and 1974 as to direct or indirect deaths is shown in Table III.

The direct obstetric deaths studied by the committee have also been classified as to cause in Table IV. One of the interesting occurrences in this data since the committee began its studies in 1957 has been the decline in direct obstetric deaths due to hemorrhage. In 1975, 59.2 per cent of the direct obstetric deaths studied by the committee was due to hemorrhage. As noted in Table IV, none of the direct obstetric deaths studied by the committee in

TABLE I
STUDY MATERIAL

	1973		1974	
	No.	Per Cent	No.	Per Cent
Total cases	11		13	
Replies received	8		12	
Replies usable	7	63.7	10	76.9

TABLE II
ADEQUACY OF DATA

Category	1973		1974	
	No.	Per Cent	No.	Per Cent
5	1	15.0	1	10.0
4	5	70.0	5	50.0
3	0		4	40.0
2	0		0	
1	1	15.0	0	

1974 was due to hemorrhage. No doubt one of the main contributing factors to this decline has been the increase in the number of deliveries occurring in Mississippi hospitals instead of at home.

TABLE III
CAUSES OF DEATH

	1973		1974	
	No.	Per Cent	No.	Per Cent
Direct	4	57.0	8	80.0
Indirect	3	43.0	1	10.0
Undetermined	0		1	10.0

TABLE IV
CAUSES OF DIRECT OBSTETRIC DEATHS

	1973		1974	
	No.	Per Cent (Of All Deaths Studied)	No.	Per Cent (Of All Deaths Studied)
Hemorrhage	2	29.0	0	
Toxemia	0		2	20.0
Infection	2	29.0	3	30.0
Vascular accident	0		3	30.0
Anesthesia	0		0	

Again, following the AMA "Guide for Maternal Death Studies" the committee determines the avoidability of those maternal deaths studied (see Table IV). Avoidability is judged in an ideal academic sense. This concept involves three assumptions. First, the physician possessed all the knowledge currently available relating to the factors involved in the death. Second, by experience, he had reached a high level of technical ability. Third, he had available to him all the facilities present in a well organized and properly equipped hospital. Because of the austerity of these criteria, it is then desirable to determine avoidable factors involved in the death rather than label the death preventable and this is done in Table VI.

TABLE V
AVOIDABILITY

	1973		1974	
	No.	Per Cent	No.	Per Cent
Avoidable	5	71.0	6	60.0
Non-avoidable	2	29.0	2	20.0
Undetermined	0		2	20.0

TABLE VI
AVOIDABLE FACTORS

	1973		1974	
	No.	Per Cent	No.	Per Cent
Professional	4	67.0	3	33.3
Hospital	0		0	
Patient	1	16.5	3	33.3
Undetermined	1	16.5	3	33.3

SUMMARY

Maternal mortality in Mississippi continues to decline and this is no doubt reflective of a number of factors, including better obstetrical care for maternity patients and a lower birth rate. Also, hopefully the decision of the Mississippi State Medical Association to establish a committee in 1957 to survey, study and report maternal mortality cases has had some impact. ★★★

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Radiologic Seminar CLXVIII:

Carcinoma of the Prostate—Stage C

B. L. SULLIVAN, M.D.
Columbus, Mississippi

CARCINOMA OF the prostate gland is the third most common malignancy in the male.¹ Its frequency of occurrence is exceeded only by lung cancer and colo-rectal cancer. There are an estimated 35,000 new cases of cancer of the prostate in the United States each year.² Thirty-nine per cent, or approximately 13,000 of these, will be Stage C when the original diagnosis is established.

Stage A and B carcinomas are limited to the prostate gland (they do not invade the capsule) and, therefore, can be treated and cured by radical prostatectomy.

Stage D carcinomas show widespread metastasis (bone, lung, etc.) and are candidates for palliative measures only.

Stage C carcinomas represent those that locally invade through the prostatic capsule. Thirty-one per cent show metastasis to pelvic nodes.³ These tumors cannot consistently be removed surgically, because of extension outside the prostatic capsule across fascial planes and dissection line. They cannot be cured with external radiation therapy alone, because of the high tumoricidal dose required (7,000 to 8,000 rads). Doses of this magnitude to the primary lesion and to the pelvic lymph nodes through large portals result in an unacceptably high rate of severe radiation complications (dermatitis, cystitis, proctitis, necrosis, etc.).

Efforts by numerous research teams to improve the salvage rate in patients with Stage C carcinoma of the prostate have resulted in a combination of surgical and radiation programs.

Currently, Stage C carcinomas are being treated by:

1. Surgical exploration with bilateral pelvic lymphadenectomy.
2. Interstitial implantation of the prostatic tumor with radioactive gold grains at the time of surgery.

3. External beam radiation to bring the radiation dose level in the primary tumor to tumoricidal levels.

This combination provides a logical attack on the malignancy. The primary lesion is controlled by the combination of radioactive gold seed implant (3,000 rads) and external beam therapy (5,000 rads). This provides a tumoricidal dose of 8,000 rads to the primary lesion. Pelvic node metastases are controlled by the bilateral pelvic lymphadenectomy.

The Royal Marsden Implantation Gun Mark III (see Figure 1) facilitate the interstitial implantation of the radioactive gold grains. This instrument increases accuracy in positioning the gold grains, and decreases the time involved, thus reducing radiation exposure to personnel.

Lymphangiograms are useful in these patients for two reasons. The lymphangiogram studies frequently pinpoint metastasis to pelvic nodes (see Figure 2), thus providing the surgeon with information that is helpful during the lymphadenectomy. The pelvic lymph nodes retain the contrast media for several days. Comparison of preoperative and operative films (see Figure 3) show when all pelvic nodes have been removed.

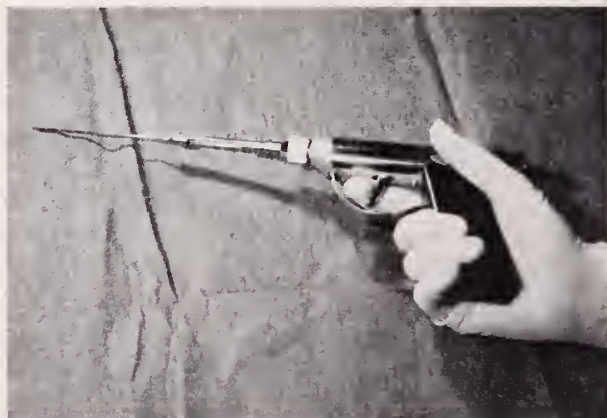


Figure 1. Royal Marsden implantation gun used to implant prostate carcinomas with radioactive gold grains.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Lowndes General Hospital, Columbus, MS.



Figure 2. Lymphangiogram aids surgeon by demonstrating pelvic lymphatics and shows metastasis to pelvic nodes. This patient had metastasis in pelvic nodes on the left that were removed by pelvic lymphadenectomy.

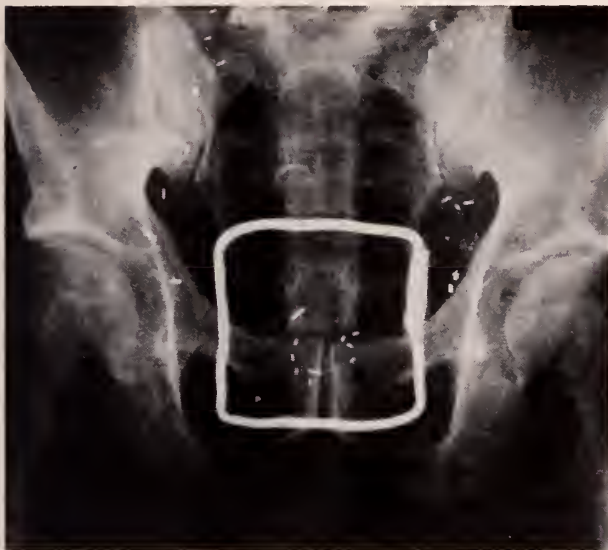


Figure 3. Film shows all pelvic nodes removed. Radioactive gold grains (arrows) have been implanted into prostatic carcinoma. The Rotational Cobalt 60 Teletherapy portal is outlined by lead wire.

All patients receive a total body bone scan. Evidence of skeletal metastasis means that the patient's disease is Stage D (see Figure 4), and he is no longer a candidate for a curative procedure.

Results have been gratifying. Cure rates of 60 per cent are being reported by most centers using this technique.^{1,3} Complications are minimal. The

5,000 rads external beam therapy through a small portal (six by six centimeters) is well tolerated. Radiation cystitis and proctitis rarely occur, and are mild and transient when present.

CONCLUSION

A current program for management of Stage C carcinoma of the prostate is presented. Cure rates are gratifying. Complications are minimal. This form of treatment is rapidly becoming more popular and widely used. ★★★

2526 5th Street N. (39701)

EDITOR'S NOTE: Many centers still treat Stage C carcinoma of the prostate with external irradiation alone. There are current ongoing studies to determine the relative merits of external irradiation either alone or with adjuvant hormonal therapy.



Figure 4. Total body bone scan shows "hot spots" in right scapula, right rib cage, spine, pelvis and right femur due to metastatic carcinoma of the prostate gland. This classifies the patient's malignancy as Stage D.

REFERENCES

1. Fletcher, G. H.: Radiotherapy, Second Edition.
2. American Cancer Society: 1971 Cancer Facts and Figures.
3. Carlton, C. E., Hudgins, P. T., Guerriero, W. G. and Scott, R.: Radiotherapy in the Management of Stage C Carcinoma of the Prostate. *J. Urology*, 116:206-210.



The President Speaking

A Question of Upholding the Law

LYNE S. GAMBLE, M.D.
Greenville, Mississippi

SECTION 41-3-1, Mississippi Code of 1972 provides in part that there will be 11 members of the Mississippi State Board of Health appointed by the Governor and that "... eight of the appointive members shall be regular qualified physicians of the state and members of the state medical association. They shall be nominated to the governor by the state medical association, three from each congressional district in the state from which number the governor shall appoint one."

In reading this Statute as it pertains to physician members of the State Board of Health, one finds the word "shall" used three times. The physicians shall be members of the state medical association; they shall be nominated by the state medical association, and the Governor shall appoint one of the nominees. Webster's Dictionary states that "shall" is "used in laws, regulations, or directives to express what is mandatory."

Governor Finch has made two appointments to the Mississippi State Board of Health which were not from among nominees of the Mississippi State Medical Association and the association has formally protested these appointments as not being in accordance with the law. This is the first time such a situation has occurred since the Department of Public Health was organized in 1897.

Governor Finch has publicly stated that Section 41-3-1 is unconstitutional and that he is therefore not bound by it. Any high school civics student knows that the legislative branch of government passes laws and the judicial branch, not the executive branch, interprets the law and rules on its constitutionality. Governor Finch as a member of the bar certainly knows this. It is why "we are a nation of laws and not of men." Moreover, Governor Finch as the state's chief executive officer has sworn to uphold the laws of the state of Mississippi.

Section 41-3-1, Mississippi Code of 1972 is a law of the state of Mississippi. If the Governor wishes to ask the Legislature to change it or any other state law, he is certainly privileged to do so. His proposal to the Legislature for changing the state's law dealing with gubernatorial succession is an example of the process. Until the law is changed, however, whether it's gubernatorial succession or appointments to the Mississippi State Board of Health, the only question is whether the Governor intends to uphold the law. ★★★



The Future Practice of Medicine

The 1976 bicentennial of our nation stimulated many reviews of our past history. Medicine was in-

Using State Hospitals as Prisons

The Mississippi Psychiatric Association adopted the following policy statement at the Jan. 22, 1977 meeting.

"During 1976 the membership of the Mississippi Psychiatric Association became aware that East Mississippi State Hospital and Mississippi State Hospital were used as prisons for persons without mental illness or emotional disorder who had been found guilty of criminal activity related in large part to illegal drugs.

"It is the carefully considered opinion of the Mississippi Psychiatric Association that this is gross misuse of these hospitals, mainly because it seems to be a harkening back to past centuries when mental illness and criminal behavior were not distinguished. We feel it is extremely important that measures be taken immediately to rectify this situation and to prevent any recurrence, ever, in the interest of all people with mental illness and emotional disorders who seem to so often be without defense against such abuse as this.

"We further pledge to do what we can to see that this is changed and does not recur."

cluded with various reviews of regional and national advancements during that period. Virtually all such studies documented the tremendous advancements in technology, patient management, drug therapy, diagnostic aids, and control of previously uncontrollable diseases over the past 30 to 40 years. All of these advancements have occurred with medicine operating as a free enterprise. The system responsible for these advancements is now threatened with ever increasing supervision, regimentation, professional review, repeated inspections, consumer control of boards and agencies governing medical activities, and numerous other third party intrusions. With these developments, what will the next 100 years be like? Even of more immediate concern, what will the next 10 years produce?

There is no question that technologically we will advance. However, will the practice of medicine advance or will it become severely hampered by ever increasing external controls? To prevent such a decline of our profession, every physician must serve as an ambassador and freely give of their time and effort to combat these trends. This unified effort is necessary at the local, county, state, regional, and national levels. To retain control over our profession this must be done immediately and aggressively.

MYRON W. LOCKEY, M.D.
Associate Editor
Jackson, MS

Medico-Legal Brief

CHIROPRACTORS MAY NOT USE MECHANICAL DEVICES

Chiropractors are limited to palpitation and adjustment by hand only and may not use mechanical devices in the practice of chiropractic, the South Carolina Supreme Court ruled.

Fifty-eight licensed chiropractors filed suit charging that the State Board of Chiropractic Examiners and the Attorney General construed the law relating to chiropractors too narrowly. The law defined "chiropractic" as the science of palpating and adjusting the articulations of the human spinal column by hand only. The chiropractors used numerous devices in their practices for diagnosis and treatment. Among the devices and treatments used are spinalator, diathermy, ultrasound, neurothermograph, x-ray hemoglobinometer, otoscope, petechiometer, goinometer, dynamometer, urinalysis, back supports, heel lifts, diet, vitamins, hydrocollator and activator.

The chiropractors sought to enjoin the Board and the Attorney General from interfering with their practices. The Board and Attorney General filed a counterclaim requesting the court to declare use of mechanical devices unlawful. A trial court granted judgment for the chiropractors, and the Board and Attorney General appealed.

Reversing the trial court's decision, the high court said that the statute limited chiropractic to use of the hands only. The statute did not authorize use of mechanical means in diagnosis, analysis or treatment as an aid in the practice of chiropractic. Palpitation meant diagnosis by feeling with the hand, the court said. The restrictive interpretation of the statute did not exceed the state's police power, nor violate chiropractors' rights to privacy, due process or equal protection, the Supreme Court concluded.

The Supreme Court remanded the case to the lower court, where the Board could apply for an injunction.—*Bauer v. State of South Carolina*, 227 S.E.2d 195 (S.C.Sup.Ct., July 16, 1976)



BROOKS, MICHAEL P., Laurel. Born Winston Salem, NC, Jan. 5, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned otolaryngology residency, same, 1972-76; elected by South Mississippi Medical Society.

BROWN, DOUGLAS C., Laurel. Born Washington, DC, Dec. 29, 1942; M.D., University of Virginia School of Medicine, Charlottesville, 1968; interned Tulane Charity Hospital, New Orleans, LA, one year; orthopedic surgery residency, Ochsner Foundation Hospital, New Orleans, LA, 1972-75; fellowship, pediatric orthopedic surgery, Newington Children's Hospital, Newington, CT, 1975-76; elected by South Mississippi Medical Society.

DE BERARDINIS, MICHAEL C., Houston. Born Wichita, KS, Sept. 12, 1942; M.D., Louisiana State University School of Medicine, New Orleans, 1967; interned Confederate Memorial Hospital, Shreveport, LA, one year; urology residency, St. Joseph's Hospital, Houston, TX, 1968-69; urology residency, University of Texas, Houston, TX, 1972-74; elected by Northeast Mississippi Medical Society.

HOLBERT, ROBERT D., Jackson. Born San Francisco, CA, Aug. 28, 1940; M.D., Tulane University School of Medicine, New Orleans, LA, 1967; interned University of Texas, San Antonio, TX, one year; internal medicine residency, Tulane, New Orleans, LA, 1970-72; nephrology residency, Ochsner Hospital, New Orleans, LA, 1972-73; nephrology residency, LSU, New Orleans, 1973-74; elected by Central Medical Society.

HUTCHINSON, CLYDE M., Tupelo. Born Columbus, MS, Aug. 18, 1943; M.D., Tulane University School of Medicine, New Orleans, LA, 1969; interned University of Alabama, Birmingham, one year; surgery residency, same, 1970-71; surgery residency, Ochsner, New Orleans, 1971-74; elected by Northeast Mississippi Medical Society.

JORDAN, BILLY J., Grenada. Born Crossett, AR, Oct. 14, 1930; M.D., University of Arkansas School of Medicine, Little Rock, 1960; interned Bethany Methodist Hospital, Kansas City, KS, one year; radiology residency, Baptist Medical Center, Little Rock, 1961-64; elected by North Central Medical Society.

MAYO, JOHN M., Columbus. Born Sallisaw, OK, Mar. 28, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned Hillcrest Medical Center, Tulsa, OK, one year; elected by Prairie Medical Society.

SONGCHAROEN, SOMPRASONG, Jackson. Born Thailand, May 23, 1941; M.D., University Medical Sciences & Sirirai Hospital, Thailand, 1966; interned Grace Hospital, Detroit, MI, one year; surgery residency, same, 1968-69; fellowship, hand surgery,

same, Jan. 1970-June 1970; surgery residency, University of Maryland Hospital, 1970-74; elected by Central Medical Society.

STUBBLEFIELD, EARL T., Jackson. Born Ft. McClellan, AL, April 29, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned and ob-gyn residency, same, 1970-74; elected by Central Medical Society.



DEATHS



MCRREE, JAMES TIMOTHY, Louin. Born Wilmot, AR, Aug. 24, 1917; M.D., University of Tennessee College of Medicine, Memphis, 1943; interned U. S. Naval Hospital, Memphis, TN, one year; died Dec. 30, 1976, age 59.

ROBERTSON, THOMAS S., Jackson. Born Chicago, IL, April 21, 1900; M.D., University of Illinois College of Medicine, Chicago, 1924; interned Cook County Hospital, Chicago, IL, 1925-26; died Jan. 15, 1977, age 76.



PERSONALS

WILLIAM M. ADEN and W. GRANVILLE TABB, JR., announce their association for the practice of ophthalmology at Medical Plaza Building, 1600 North State Street, Jackson.

NAN CORLEY BRANTLEY announces the opening of her office for the general practice of psychiatry in association with WILLARD LEE WALDRON, 1060 Riverside Plaza, Jackson.

ALVIN E. BRENT, JR., and JAMES N. MCLEOD, III, of Jackson announce the association of MARCELO J. RUVINSKY for the practice of internal medicine, nephrology and dialysis with offices in Suite 425, St. Dominic medical offices.

HUGH P. BROWN announces the opening of his office for the practice of pediatric orthopedics and orthopedic surgery at 971 Lakeland Drive, Suite 510, in Jackson.

JOE A. CAMPBELL, JR., of Clarksdale announces the removal of his office to 521 Third Street.

MIKE CALDWELL of Baldwin announces his resignation from the practice of medicine. He will now be associated with the State Board of Health as a health officer.

CHARLES N. CRENSHAW, JR., announces the opening of his office for the general practice of medicine at 1011 South Main Street, Newton.

WADE S. GARNER announces the opening of his office for the practice of internal medicine in association with GAINES L. COOKE in the Green Shopping Center, Grenada.

PETER GENERELLY is new emergency room physician at Delta Medical Center in Greenville. Dr. Generelly, a Greenville native, completed an ER residency at Charity Hospital in New Orleans.

JOHN GREEN of Hattiesburg discussed diabetic eye disease at a meeting of the Hattiesburg Unit of the American Diabetes Association—Mississippi affiliate.

KAMAL ALY HASSAN announces the opening of his office for the practice of Ob-Gyn at Suite 107, Magnolia Doctors Plaza, Corinth.

BENTON HILBUN of Tupelo has been elected chairman of the medical staff for 1977 at the North Mississippi Medical Center.

THOMAS E. HOLDEN announces the opening of the Clinic for Women for the practice of Ob-Gyn at the Southwest Corner of Highway 8 and 51 in Grenada.

WAYNE A. HUGHES has associated with C. L. AUSTIN, A. J. CARROLL and E. D. JOHNSON in the practice of family medicine/general practice at 2601 Mamie Street, Medical Plaza Suite 204, in Hattiesburg.

WILLIAM G. JACKSON of Corinth has been named Northeast Mississippi Junior College "alumnus of the year" recipient.

KEN C. JONES announces his association with J. G. NASSAR for the practice of ophthalmology at the Nassar and Jones Eye Clinic, P.A., Suite 611, Medical Arts Building, Jackson.

BRUCE MCALPIN JONES has associated with The Family Clinic, P.A. at 502 Broad Street in Columbia for the practice of family medicine with W. R. CAMPBELL, T. B. WHITEHEAD and CHARLES P. BASS.

B. A. KELLETT announces the opening of his office in family practice at 405 S. 28th Street, Medical Arts Building in Hattiesburg.

PERSONALS / Continued

WILLIAM C. KELLUM of Tupelo has been elected a Fellow of the American College of Physicians.

MACK A. LAND has associated with DAVID R. THOMAS of Starkville for the practice of internal medicine at Medical Arts Clinic at 517 University Drive.

PAUL H. MOORE of Pascagoula has been named to the board of directors of Merchants and Marine Bank.

FRANCIS S. MORRISON of Jackson and UMC attended a two-day meeting of the National Workshop Committee of the American Association of Blood Banks in Atlanta.

WARREN PLAUCHE of Biloxi was named king of the 29th annual ball of Les Femmes which was held at the Biloxi Community Center.

BEN B. RADER, JR., announces his continuation in the practice of general medicine at The Rader Clinic, 115 Sharkey Avenue in Clarksdale.

Simmons Clinic for Women, P.A. announces its change of name to Jackson Clinic for Women, P.A. with offices at 1030 North Flowood Drive in Jackson. Members are ROSS F. BASS, WILLIAM S. COOK, JOHN T. KITCHINGS, EARL T. STUBBLEFIELD and HENRY H. WEBB.

J. CLINTON SMITH announces the opening of his offices at 305 S. Magnolia Street in Laurel for practice limited to pediatrics and pediatric cardiology.

Associated Radiologists, P.A. announces the association of PRENTISS L. SMITH with DAN T. KEEL in the practice of radiology at King's Daughters Hospital, Brookhaven, and Lawrence County Hospital, Monticello.

RAY STEWART, ROGER REED and JOHN WIMBERLY announce the opening of Seaway Industrial and Family Clinic located at Seaway across Access Road in Gulfport.

WILLIAM WARNER of Jackson, outgoing chief of staff of Doctors Hospital, recently took part in a ceremony handing over the gavel to JAMES BARLOW, incoming chief of staff.



Heart Pacemakers Prolong Life

Heart pacemakers that are implanted in the chest work very well in prolonging useful life. A majority of the patients survive for a number of years with the pacemakers, and death almost always is caused by an ailment not related to pacemaker failure.

These are the findings of a survey of more than 12 years of experience with the pacemakers at the University of Virginia School of Medicine, Charlottesville, reported in a recent issue of the *Journal of the American Medical Association*.

Of the 313 patients who received heart pacemakers between 1961 and 1973, there was a survival rate of 65 per cent after five years. Average age at onset of pacing was in the late 60s.

Of the 109 individuals in the study who died, only one death could be attributed directly to failure of the implanted device. The others died from a variety of causes not related to the pacemaker, says Lockart M. McGuire, M.D., and colleagues.

Death rates increased during the later years of the study, primarily because the criteria for selecting implant recipients were broadened considerably to include individuals who were considered poor risks in the earlier years, Dr. McGuire says.

But, he points out, "The benefits of cardiac pacing for even a brief period of two or three years may be highly desirable."

Recent technical innovations have improved the effectiveness of the pacemaker, particularly to extend the life of the power source to four or more years. In the earlier devices, replacement of the power source was necessary at more frequent intervals. Some now use nuclear power.

AAP Meets In New Orleans

More than 2,500 child health professionals are expected to attend the American Academy of Pediatrics' spring meeting April 16-20 in New Orleans.

The scientific sessions will start April 16 with one-day seminars planned for Saturday and Sunday—a new offering this year. Some of the topics scheduled to be covered include neonatology, neurology, rheumatology, clinical allergy and immunology, care of the critically ill child, infectious disease and antimicrobials, pediatric emergencies, pulmonary disease, renal disease, endocrinology, gastrointestinal tract disorders and adolescence.



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BRIEF SUMMARY OF PRESCRIBING INFORMATION

***INDICATIONS.** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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POSTGRADUATE CALENDAR

Mar. 15, 22, 29, April 5, 12, 19

FAMILIES IN TROUBLE: NOON-HOUR SEMINAR University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center Department of Social Work and Division of Continuing Health Professional Education, with support from the Mississippi Regional Medical Program.

Coordinators:

George Letherwood, A.C.S.W., and Alice Jackson, M.S.W., University of Mississippi Medical Center Department of Social Work.

This series of six Tuesday noon-hour seminars on counseling and families in trouble will feature videotapes of Virginia Satir, one of America's leading therapists, discussing her theories on how people interact with each other. The tapes also show marital therapy sessions with two troubled couples. The course is open to psychiatrists, psychologists, nurses, ministers, social workers and counselors. Fee: \$12. Credit: 6 contact hours, .6 CEU.

Mar. 17-19, 1977

ACUTE NEUROLOGY-NEUROSURGERY INTENSIVE COURSE University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program.

Coordinators:

Robert D. Currier, M.D., professor of medicine and chief, division of neurology, University of Mississippi School of Medicine.

Robert R. Smith, M.D., associate professor of neurosurgery, University of Mississippi School of Medicine.

Neurology problems most commonly encountered by the primary care physician will be discussed during this two-day course. Instruction will include head injury, the dizzy patient, headaches, epilepsy, sciatica, strokes, and tumors in relation to adult and pediatric neurology and

neurosurgery. The course begins at 1 p.m., Thursday, Mar. 17, and ends at 12 noon, Saturday, Mar. 19. Enrollment is unlimited. Fee: \$50. Credit: 16 contact hours, 1.6 CEU, Category I, AMA; AAFP.

Mar. 21-22 (23), 1977

HEMATOLOGY INTENSIVE COURSE University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education, with support from the Mississippi Regional Medical Program.

Coordinators:

Francis S. Morrison, M.D., professor of medicine and chief, division of hematology, University of Mississippi School of Medicine.

J. Tate Thigpen, M.D., assistant professor of medicine, University of Mississippi School of Medicine.

This two-day course will review recent advances in the basics of diagnosis and treatment in hematologic disorders. Topics will include new diagnostic tests for iron deficiency anemias, megaloblastic anemias, and a practical approach to hemolytic anemias. Instructors will discuss the hematologic side effects of commonly used drugs, a simplified approach to coagulation studies, the use of anti-coagulants, and modern use of blood component therapy. Other subjects pertinent to the primary care physician will be covered, and the course will permit adequate time for questions and discussion of clinical problems. A third optional day will offer a review of peripheral blood smears, bone marrow slides, radiologic studies, and case discussions in conjunction with a review of visual oncologic material for the associated two-day course in oncology. Fee: \$50 (\$75). Credit: 16 contact hours, 1.6 CEU, Category 1, AMA; AAFP. Credit for the additional day: 8 contact hours, .8 CEU, Category 1, AMA; AAFP.

Mar. (23), 24-25, 1977

ONCOLOGY INTENSIVE COURSE

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education, with support from the Mississippi Regional Medical Program.

Coordinators:

Francis S. Morrison, M.D., professor of medicine

and chief, division of hematology, University of Mississippi School of Medicine.

J. Tate Thigpen, M.D., assistant professor of medicine, University of Mississippi School of Medicine.

Advances in oncology now include the word "cure" for certain neoplasms, and this two-day course will update the primary care physician on these advances. Instruction includes the role and principles of chemotherapy, treatment of patients receiving immunosuppressive therapy focusing especially on side effects, and aspects of supportive care. The schedule permits participants to discuss their problem cases and ample time for question and answer periods. A third optional day will offer a review of histologic sections, radiologic studies, and special therapeutic techniques such as scarification of BCG in conjunction with a review of visual hematologic material for the associated two-day course in hematology. Fee: \$50 (\$75). Credit: 16 contact hours, 1.6 CEU, Category 1, AMA; AAFP. Credit for the additional day: 8 contact hours, .8 CEU, Category 1, AMA; AAFP.

Mar. 28-31, April 1, 1977

PEDIATRICS INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education.

Coordinator:

J. M. Montalvo, M.D., professor of pediatrics, University of Mississippi School of Medicine, and assistant professor of biochemistry, University Medical Center.

The content of this one-week course includes special problems in newborn care, neurology with special emphasis on convulsive seizures, meningitis and head trauma, care and problems of the adolescent, allergy, hematology, oncology, pediatric emergencies, cardiology, radiology, fluid and electrolytes, nephrology, endocrinology, inhalation therapy, pediatric surgery, and orthopedic problems in children. Registrants will participate in specialized pediatric techniques and in daily intake and award rounds. Fee: \$125. Credit: 40 contact hours, 4 CEU, Category 1, AMA; AAFP.

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers intensive refresher courses to meet physicians' clinical practice needs in the specialties most re-

quested. The Mississippi Regional Medical Program partially supports the series open to all physicians. Intensive courses are eligible for AMA Physician Recognition Award, Category 1, credit. Enrollment is limited, and applications are accepted in the order received. All correspondence should be addressed to Continuing Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

FUTURE CALENDAR

April 26, 1977

MISSISSIPPI THORACIC SOCIETY ANNUAL
MEETING
University Medical Center, Jackson

May 19, 1977

HEAD AND NECK CANCER WORKSHOP
Greenville

May 19-20, 1977

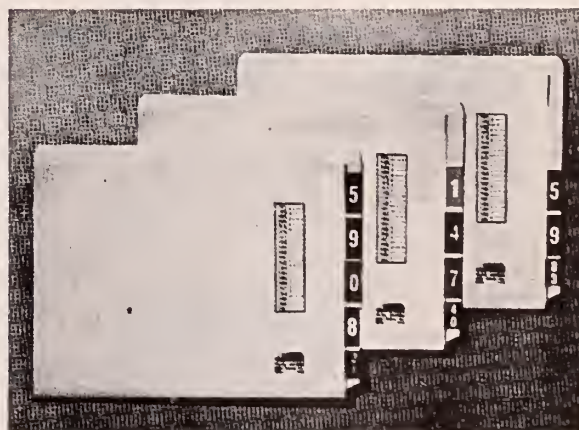
ALLERGIC DISEASES FOR THE GENERALIST
Memphis

May 23-24, 1977

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University Medical Center, Jackson

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SHCC Opposes Optometry Bill

The legislative committee of the Statewide Health Coordinating Council has recommended that the legislature not pass a bill permitting optometrists to use pharmaceutical agents for diagnosis and treatment of conditions of the human eye.

The council was formed under provisions of Public Law 93-641, the National Health Planning and Resources Development Act of 1974. Its chairman is Mr. Fred St. Clair, former executive director of the Mississippi Optometric Association.

The recommendation was announced in a letter to all members of the Mississippi House of Representatives.

SBH Adopts New Reporting Requirements

The State Board of Health, at its meeting on Dec. 11, 1975, adopted certain changes in the reporting requirements for fetal deaths and induced terminations of pregnancy. Effective Jan. 1, 1976, all induced terminations are to be reported on special new forms by the hospital in which the procedure was performed or by the attending physician if the procedure was not done in a hospital. During 1976, reports were received from hospitals and the one special clinic in the state. To date no reports have been received from physicians on terminations performed in their offices.

All physicians who are doing these procedures in their offices should contact the State Board of Health for a supply of the report forms. The reports are for statistical uses only. They do not call for either the name or the address of the patient. Names of physicians will not be released to anyone, and the reports will be destroyed as soon as the statistical information has been compiled. The State Board of Health considers it important to analyze the greatly increased use of this procedure in Mississippi and its relation to maternal and child health. In addition, state figures will be submitted to the U.S. Public Health Service for inclusion in national statistics.

Report forms and further information may be obtained from the Statistical Services Unit, telephone 354-6606, mailing address: P.O. Box 1700, Mississippi State Board of Health, Jackson, MS 39205.



MSMA's 109th Annual Session Will Offer Something for Everyone

Plan now to attend the 109th Annual Session of the Mississippi State Medical Association set for May 1-5, 1977, at the Sheraton-Biloxi.

According to Dr. J. Elmer Nix of Jackson, chairman of the MSMA Council on Scientific Assembly, convention coordinators have planned the meet to attract physicians of every specialty and their spouses.

The 12 scientific sections (anesthesiology, EENT, medicine, surgery, ob-gyn, preventive medicine, psychiatry, pathology, pediatrics, radiology, dermatology and family practice) have scheduled outstanding programs with 11 out of state essayists and many Mississippi physician speakers. Fifteen hours of MAFP postgraduate credit have been requested.

Another postgraduate education opportunity will be a Sunday afternoon seminar on genitourinary problems, sponsored by the Mississippi Urological Society and open to all convention registrants. Technical and scientific exhibits will also be featured.

Some 14 medical specialty and related organizations plan to host concurrent meetings, scientific and social, during the convention week, Dr. Nix said.

Association business will be conducted in the House of Delegates (meeting Monday and Thursday mornings) and the reference committee meetings on Monday afternoon.

Alumni groups planning social events for Monday evening include Ole Miss, Tulane and Tennessee. The association's annual fellowship party is slated for Tuesday evening.

A mixed doubles tennis tournament is a special event of this year's annual meeting. For more information, contact Dr. Henry Tyler, 1600 North State Street, Jackson 39202.

The MSMA Auxiliary has scheduled its 54th annual session for May 1-4 with headquarters at the Sheraton-Biloxi.

All reservations will be handled through MSMA; contact Barbara Shelton at association headquarters in this regard. For more convention information, write Council on Scientific Assembly, Box 5229,

Jackson 39216. The complete annual session program will be published in the April issue of the JOURNAL.

Influenza Vaccine Recommendations Are Revised

On Feb. 8, 1977, Secretary of Health, Education, and Welfare, Joseph A. Califano, Jr. announced the following recommendations:

1. The moratorium on bivalent influenza vaccine (A/New Jersey and A/Victoria) will be lifted. It is recommended that bivalent vaccine be given to high-risk persons as previously defined by the Advisory Committee on Immunization Practices (ACIP). Special attention should be given to persons residing in nursing homes and health care institutions.
- For the general population, discretionary use of bivalent vaccine will be permitted for individuals most likely to be exposed, such as those who care for high-risk individuals.
2. The moratorium on monovalent B/Hong Kong influenza vaccine will be lifted.
3. The moratorium on monovalent A/New Jersey influenza vaccine will remain in effect. Careful surveillance will continue, and appropriate action will be taken at the first sign of an A/New Jersey influenza outbreak.

A new informed consent form—setting forth the risks of Guillain-Barré following influenza immunization—is being prepared and should be signed by potential vaccinees before receiving influenza vaccine, according to Durward Blakey, M.D., director, Bureau of Disease Control, Mississippi State Board of Health.

Senate Votes on Chiropractic Services

The Mississippi Senate has passed a bill (SB 2373) which would require all insurance companies writing health insurance in Mississippi to cover services rendered by chiropractors.

Billed by its proponents as an "insurance equality act" the measure was passed 37 to 12 on a roll call vote after a section allowing compensation for chiropractors through Medicaid was deleted. The bill was introduced by Senator Nap Cassibry of Gulfport. It still must be acted on by the Mississippi House of Representatives.

Medicaid Will Reconsider Drug Action

The Mississippi Medicaid Commission will seek a review from two physician advisory committees of its policy of excluding certain anti-arthritic and peripheral vasodilator drugs from the Medicaid drug formulary. The commission excluded the drugs and placed a copayment on Medicaid drug recipients in an action last summer which has led to numerous protests by civil rights groups including a demonstration at the Capitol.

The advisory committees will be appointed by the commission from among nominees submitted by the Mississippi State Medical Association and the Mississippi Medical and Surgical Association. The latter organization is composed of some 50 black physicians in the state. The Dean of the University of Mississippi School of Medicine will name the chairman of each advisory committee.

MSU Hosts College Health Association

The Southern College Health Association will meet on the Mississippi State University campus on Mar. 10-12, 1977. This association is composed of South Carolina, Georgia, Alabama, Florida and Mississippi and is an affiliate of the American College Health Association.

Theme of the meeting will be "The Prospective Approach to the Practice of Medicine on the College Campus."

The meeting will be attended by health professionals from colleges and universities in the area and will include physicians, nurses, administrators, technicians and students, according to Dr. John C. Longest, director of the MSU student health center and president-elect of SCHA. Dr. Longest also serves as chairman of the MSMA ad hoc committee on College Health.

Mississippi physicians who will participate are: Dr. Longest, Dr. Joe R. Bumgardner of Starkville, Dr. Morris Williams of Jackson, Dr. David R. Thomas of Starkville, Dr. Francis Morrison of Jackson, and Dr. W. C. Warner of Jackson.

For further information, contact Dr. Longest, P.O. Box 5448, Mississippi State, MS 39762.

Central Medical Society Gives to Guyton Fund

The Central Medical Society has contributed \$1,000 to the Billy S. Guyton, M.D., Memorial Medical Education Loan Fund at the University of Mississippi Medical Center.

The Guyton Fund was established in 1972 through the joint efforts of the Mississippi State Medical Association, the University of Mississippi Medical Alumni Chapter and the Medical Center. Contributions through the three member agencies, and other interested individuals or organizations, support the ongoing fund.

The society's contribution will provide needed loan monies for state medical students, according to UMC Vice Chancellor and School of Medicine Dean Dr. Norman C. Nelson. Dr. Max L. Pharr was president of the medical group when the donation was made.

"The Central Medical Society is to be commended for its generous gift to the Guyton Fund," Dr. Nelson said. "The fund was created to honor one of Mississippi's most distinguished medical educators and to give financial assistance to medical students for generations to come. This gift will provide educational loans for two future state physicians."

Dr. Guyton was dean of the Mississippi medical school from 1935 to 1944, when he was named dean emeritus. He headed the Guyton Clinic in Oxford until his death in 1971 at the age of 87.

An ear, nose and throat specialist, Dr. Guyton was a fellow of numerous organizations and past president of the Mississippi State Medical Association and the Louisiana-Mississippi Ophthalmology-Otolaryngology Society.

Surgical Forum IV Is This Month

Over 250 surgeons representing 33 states from Washington to Rhode Island and California to Florida have pre-registered for Surgical Forum IV.

The University of Mississippi Medical Center post-graduate seminar is Mar. 10-12 at the Holiday Inn Downtown in Jackson.

Dr. James D. Hardy, UMC professor of surgery and department chairman, and Dr. William O. Barnett, UMC professor of surgery, are coordinators for the annual seminar.

Eleven noted surgeons will join Medical Center faculty in discussions on general, pancreatic and malignant disease problems.

UMC lecturers and their topics include Vice Chancellor Dr. Norman C. Nelson, "a rational approach to the treatment of thyroid cancer," Dr. Richard C. Miller, professor of surgery and assistant professor of pediatrics, "diaphragmatic problems in infants and children," and Dr. W. C. Shands of Jackson, clinical associate professor of surgery, "diagnosis and management of salivary gland tumors."

Dr. Hardy's subject is "arterial injuries," and Dr. Barnett's "peritoneovenous shunting for intractable ascites."

Other UMC faculty participating are Dr. Richard



Dr. Robert M. Zollinger, left, professor and chairman emeritus, Department of Surgery, Ohio State University College of Medicine, is one of 11 noted surgeons who'll join University of Mississippi Medical Center faculty for Surgical Forum IV. UMC professor of surgery and department chairman, Dr. James D. Hardy, is shown at right.

J. Field of Centreville, clinical assistant professor of surgery; Dr. J. Harvey Johnston, Jr. of Jackson, clinical professor of surgery; and Dr. J. Tate Thigpen, UMC assistant professor of medicine.

The School of Medicine and UMC Division of Continuing Health Professional Education sponsor the annual event. Attendance is by invitation, and advance registration is required.

Newborn Art Contest Enters Second Year

The University of Mississippi Medical Center Newborn Center and the March of Dimes will sponsor an art competition again this year to create greater public awareness of the importance of perinatal care.

State obstetricians and pediatricians, county health officers, and nursing professionals will receive information on the contest this month.

"We hope health professionals who paint or work in another art medium will enter the competition this year," a UMC spokesman said, "and help us tell Mississippians about the contest by posting a contest brochure in their waiting rooms."

Artists may submit works in any medium in high school, college and university, or adult divisions. There is no entry fee for high school and college artists, but adults pay a \$2.00 fee for each entry.

Each work submitted must illustrate some aspect of maternal and infant care, or the artist's perception of a mother and baby. Entries should be ready for showing and include a brief narrative of the intent of the work in relation to the theme.

Works will be displayed and contest winners announced at a formal showing at the Medical Center on June 26. Those selected for purchase awards of \$75, \$150 and \$250 will become part of the Newborn Center's permanent collection. The work designated "best in show" will be used as art for the Newborn Fund benefit Christmas card in 1977.

More than 40 state artists entered the contest last year, the UMC spokesman said. Lewis West's limestone sculpture "Mother and Child" earned the adult purchase award and designation as best in show. An embossed impression of the work is art for all-occasion note cards currently on sale through Medical Center Special Services.

Deadline for entries for the 1977 competition is May 1. They may be mailed to Special Services, University Medical Center, 2500 North State Street, Jackson 39216, or hand delivered weekdays between 8 a.m. and 5 p.m.

ORGANIZATION / Continued

UMC Adds Two New Faculty Members

Two new faculty members have been appointed to the medical school and centerwide teaching staff at the University of Mississippi Medical Center.

The appointments of Dr. Michel Elias Rivlin as assistant professor of obstetrics and gynecology in the School of Medicine and Dr. Edward Everett Smith as Medical Center instructor in pathology were announced by Vice Chancellor Dr. Norman C. Nelson on approval of the Board of Trustees of the Institutions of Higher Learning.

Dr. Rivlin, a native of South Africa, earned the M.B. and Ch.B. degrees from the University of Witwatersrand Medical School in Johannesburg. He took residencies in surgery and ob-gyn at General Hospital in Johannesburg and North Middlesex, Central Middlesex and Hammersmith hospitals in London, England.

A member of the Royal College of Obstetrics and Gynecology and the Royal College of Surgeons, Edinburgh, Scotland, Dr. Rivlin was principal specialist, ob-gyn department, Baragwanath Hospital and the University of Witwatersrand Medical School before assuming his duties at UMC.

Dr. Smith, a 1959 alumnus of the Mississippi medical school, earned the B.S. degree at the Massachusetts Institute of Technology.

A UMC fellow in physiology and biophysics in 1959-1960, Dr. Smith is a former UMC assistant professor of physiology and biophysics. He took his pathology residency at the Medical Center.

Why Health Care Costs so Much

Editor's Note: JOURNAL MSMA quotes the following article on health care costs from "The Trumpet," published bi-monthly by St. Dominic-Jackson Health Services.

Here's a little story that presents the other side of the health cost story. It starts with an all-too-common newspaper headline which reads: "CAR HITS TREE—DRIVER'S CONDITION CRITICAL AT LOCAL HOSPITAL."

The article then goes on to tell of an early morning auto accident—how the patient was picked up and brought into the hospital in critical condition at

2:00 a.m. Injuries include several fracture and internal injuries. It's a nip-and-tuck fight until around 8:00 a.m. when the patient is reported "off the critical list."

All this is just a routine sort of news item—you will find one in your morning paper often. And it is a routine experience in any hospital—but consider what has been called into action: two emergency room nurses; one orderly; one E.R. nurse aide; one admitting officer; one E.R. physician; one surgeon (on call); one pharmacist; one anesthetist; two operating room nurses; one orthopedic surgeon; one central services employee; one radiologic technologist; one radiologist; one medical technologist; one telephone operator; staff of intensive care unit—three nurses and one nurse aide.

In a six hour period, 26½ man hours by 21 members of the health care team were directed toward saving one life. And before the sun sets again, many others will have an impact on that patient's well-being—administration, floor nurses, medical records, housekeeping, accounting, laundry, maintenance, etc., etc., etc.

Tri-State Thoracic Sessions Are Held



Mississippi physicians, Dr. Walter Treadwell (left), president of Mississippi Thoracic Society and chairman of Hinds County Chapter, Mississippi Lung Association; and Dr. Karl Stauss (far right) participated in the 21st annual Tri-State Thoracic Case Conference held recently in Biloxi. Dr. Donald Greenberg (center), professor of pathology, Baylor College of Medicine, Houston, TX, delivered the keynote address to physicians of Mississippi, Alabama and Louisiana. Lung Association and Thoracic Societies of the Tri-State area sponsored the two-day postgraduate session.

PSRO Regulations Are Issued

After more than two years of preparation, proposed regulations have been published on what PSROs will review and how they will do it. The regulations appear in the January 24 and 25 issue of the *Federal Register*. Sixty days are allowed for comments.

The proposed PSRO review system contains three components: (1) reviews for "medical necessity and appropriateness" of both hospital admission and continued stay within three days of entering the hospital; (2) studies to evaluate quality of medical care; and (3) gathering and analyzing profiles of physicians, institutions and patients.

The PSRO can present its own plan for conducting required review if the plan is as effective and efficient as the regulation's requirements.

The regulations also outline how the PSRO takes over the review authority in medical decisions. The PSRO's decision is binding on Medicare and Medicaid fiscal intermediaries.

AMA's NHI Proposal Is Explained

Four key lawmakers, representing both political parties, have introduced into the new Congress an American Medical Association proposal for national health insurance.

Association president Richard E. Palmer, M.D., urged the 95th Congress and the Carter Administration to consider carefully "this forthright approach to national health insurance. This bill would extend health insurance to every American at a cost the nation could afford. It is a viable solution to the problem of providing quality health and medical care to everyone."

The Comprehensive Health Care Insurance Act of 1977 was introduced in the Senate by Senator Clifford P. Hansen (R-Wyo.) and in the House by Reps. Tim Lee Carter (R-Ky.), John M. Murphy (D-N.Y.), and John J. Duncan (R-Tenn.) as S. 218 and H.R. 1818 respectively. Sen. Hansen is a member of the Senate finance committee, Representatives Carter and Murphy are members of the House Interstate and Foreign Commerce Committee and Representative Duncan is a member of the House Ways and Means Committee. Each of the committees is expected to play a part in any NHI program passed by the Congress.

The medical profession's NHI plan would build on the structure of the present system of employer-employee group health insurance plans, mandating each employer to provide comprehensive and catastrophic benefit coverage with the employer picking up at least 65 per cent of the cost. Employees would not be compelled to participate.

The self-employed as well as the non-employed could purchase qualified private health insurance, through pools if needed, at a cost not more than 125 per cent of the cost of group plans. They would have all or part of the premium paid for by the federal government depending upon their income tax liability.

Small businesses that found the mandated plan an added financial burden would receive federal assistance.

Medicare beneficiaries could purchase supplemental insurance to bring Medicare benefits to a par with those offered elsewhere, with the government assisting people with limited resources. Medicaid would, for the most part, be supplanted.

After a certain level of co-insurance was reached, depending upon income, insurance would cover all remaining expenses as a complete protection against catastrophic costs.

The co-insurance factor would deprive no one of needed care, the sponsors said. The absolute maximum that any individual would have to pay would be \$1,500; the absolute maximum for any family would be \$2,000 in any given year.

Drug Research and Development Goes Abroad

The 1962 amendments to the Food, Drug and Cosmetic Act have led U.S. drug manufacturers to move a large part of their research and development operations abroad, says Henry Grabowski, professor of economics at Duke University, in *Drug Regulation and Innovation: Empirical Evidence and Policy Options*.

Grabowski says the majority of new-chemical-entity discoveries by U.S. firms are now first introduced abroad—unlike the procedures used prior to the 1962 amendments. Among U.S. multinationals, he says, this research and marketing strategy is unique to the drug industry and directly related to the stringent regulatory conditions in the United States. Additionally, Grabowski says that the annual rate of new chemical entities introduced has fallen sharply since the 1962 amendments took effect, from an annual rate of 56 during 1950-1961 to a yearly rate of 17.

Zinc Tablets Help Control Acne

Tablets of zinc are effective in controlling acne, a Swedish research group reports in a recent issue of *Archives of Dermatology*, a scientific journal of the AMA.

Gerd Michaelsson, M.D., of Uppsala University, Sweden, and colleagues gave their patients three tablets daily of zinc sulfate in effervescent form. The tablets were dissolved in water and taken after meals three times daily.

After four weeks there was a significant decrease in the number of blackheads, whiteheads and pimples. After 12 weeks, the acne had been reduced by 85 per cent in those treated, Dr. Michaelsson reports.

Some 64 patients were included in the study. More than half had had acne for more than two years, and many had been afflicted for more than five years. Ages ranged from 13 to 25 years.

The Swedish physician says he does not yet know how zinc works to reduce acne.

Family Donates Boswell Portrait to UMC



Members of the family of the late Dr. Henry Boswell, first and only superintendent of the Mississippi State Sanatorium at Magee, presented Dr. Boswell's portrait to the University of Mississippi Medical Center at the fifth annual Boswell Lecture on the campus. UMC Vice Chancellor Dr. Norman C. Nelson, fourth, left, accepted the Karl Wolfe work on behalf of UMC. Family members present included, from left, Dr. H. Karl Stauss, Mrs. Stauss, Mrs. Howard Dear, Dr. Nelson, Dr. H. Davis Dear, Mrs. Henry Boswell, Mrs. Samuel Johnson and Mrs. W. L. Tyson.

Physicians Attend UMC Psychiatry Course



Dr. S. D. Taggart of Snackover, Ark., Dr. Robert Cates of Madison, Dr. B. Frank Vogel of Hattiesburg, and Dr. Joe Johnston of Mount Olive were among the physicians who attended the two and one-half day psychiatry intensive course at the University of Mississippi Medical Center.

Congressmen Call for Swine Flu Hearings

Two members of a House subcommittee on health have announced that they have "authoritative information" indicating the swine flu inoculation program was "seriously mismanaged," marked by "policy misjudgments" and "in some instances, the law may have been violated."

Reps. Henry A. Waxman (D-Cal) and Andrew Maguire (D-NJ) have called for "full hearings . . . at the earliest possible date" because of the "new information."

Waxman and Maguire, though they declined to elaborate or name sources, listed eight areas in which "information available to us" raised questions. They had "learned," they said:

1. That the cost of the program may significantly exceed the \$135 million appropriated for it;
2. That because of the cost overrun, there have been diversions of funds from venereal disease control, school immunizations and other public health programs;
3. That there are still no contracts with the manufacturers of the vaccine;
4. That it remains unknown whether those inocu-

lated will be protected for the entire 1977-78 season;

5. That HEW recommended inoculation of all children when it knew there was insufficient vaccine;
6. That because a higher profit could be made by the manufacturers by combining A Victoria with swine flu vaccine in bivalent doses, a disincentive against the production of monovalent A Victoria was provided, and in fact no monovalent A Victoria vaccine has been available to the public for several months;
7. That the Justice Department has assigned only one attorney to handle the 70 damage claims filed so far;
8. That the informed consent requirement of the law may not have been fulfilled for many who received the vaccine.

Physicians Get Guides On High Blood Pressure

A useful guide to physicians on how to manage high blood pressure in their patients is offered in a recent issue of the *Journal of the American Medical Association*.

The guide is a report of the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure, a cooperative study involving nine national associations and government units concerned with the ongoing nationwide campaign against high blood pressure.

The committee was formed by the National Heart, Lung, and Blood Institute, Bethesda, MD. Chairman is Marvin Moser, M.D., of White Plains, NY, senior medical consultant to the National High Blood Pressure Education Program.

The report gives six general recommendations to physicians for the detection, evaluation and treatment of high blood pressure in adults:

1. Any group measuring blood pressure should have resources available for referral, confirmation, and follow-up.
2. Virtually all patients with a diastolic pressure of 105 or greater should be treated with anti-hypertensive drug therapy.
3. For persons with diastolic pressures of 90 to 104, treatment should be individualized, with consideration given to other risk factors.
4. The evaluation of patients with high pressure can be limited to a few baseline tests in most instances.
5. A stepped-care approach is advocated as a cost-effective method of treating most patients.

Stepped care means the beginning of therapy with a small dose of a drug, increasing the dose of that drug, and then adding, one after another, other drugs as needed.

6. Treatment includes plans for facilitating long-term maintenance of blood pressure control.

"Management of high blood pressure must be considered a lifelong endeavor," the report says.

Most patients with uncomplicated high blood pressure have few, if any, symptoms related to their pressure; however, drug therapy may produce unwanted effects about which patients should be forewarned, the committee points out.

In an accompanying editorial, *JAMA* Editor William R. Barclay, M.D., points out to physicians that the guidelines in the report are useful in general terms, but should not be considered a rigid directive, and that treatment must be tailored to the individual patient.

Vitamin C's Effect on Common Cold Studied

Vitamin C can help young girls with the common cold, and also is of some value to young boys. But the impact of the vitamin "showed no significant overall treatment effect on cold symptoms," says a research report in *JAMA*.

Judy Miller of the Indiana University School of Medicine, Indianapolis, and colleagues utilized 44 school-age twins to test the controversial theory that Vitamin C can reduce frequency and severity of colds. The twins were used to rule out the possibility of differences in inborn hereditary resistance to colds.

Half of the twins received daily doses of Vitamin C and the others an inert substance. Mothers didn't know which substance their children were receiving. The project continued for five months. Mothers reported on how many colds and how severe the colds were.

Response to the Vitamin C treatment was not uniform in all of the twins, Ms. Miller reports. Treated girls in the youngest two age groups had significantly shorter and less severe illnesses, and illnesses were somewhat less severe in the youngest group of boys, she found.

An interesting effect of the treatment program occurred unexpectedly. The seven treated twins among the youngest boys grew an average of about one-half inch more than their untreated co-twins. But, says Ms. Miller, the effect on growth must be confirmed before it can be accepted as an established fact.

ORGANIZATION / Continued

Certificate-of-Need Impact Studied

A study of the impact of state certificate-of-need laws during the period 1968-1972 has concluded that such laws did not dampen hospital cost inflation and may have in fact exacerbated it.

The study, which was funded by the National Center for Health Services Resources, U.S. Department of H.E.W., was conducted by Johns Hopkins University. It concluded that the impact of state certificate-of-need programs on hospital investment patterns, utilization and costs showed that such programs did not substantially affect total investment in the hospital sector; rather, it encouraged a redirection of investment capital from bed expansion to new equipment and services. The net effect of this pattern was to lower overall utilization of inpatient hospital services and raise costs of care.

During the period of the study 24 states adopted some version of certificate-of-need legislation as a means to moderate cost inflation in the health sector.

Health Care Costs Are Analyzed

Recent statements in the press and elsewhere have stated that physicians' fees have increased twice as fast as the cost of living.

To set the record straight, using 1967 as a base of 100.0 the 1976 Consumer Price Index for all items was 172.6 and for all services was 183.2. This means it took \$172.60 more to purchase the same market basket of goods in 1976 as \$100.00 purchased in 1967. The same services purchased for \$100.00 in 1967 cost \$183.20 in 1976.

The 1976 Consumer Price Index for physicians' fees was 192.2 or some 20.0 higher than the index for all items and 10.0 higher than the index for all services.

The Social Security Administration cites inflation (i.e. too much money chasing too few goods) as causing some 50 per cent of the increase in health care costs since 1965, which is the year the Medicare and Medicaid programs were enacted. In 1965 total health expenditures in the United States were \$38.9 billion. In fiscal year 1976 total expenditures were \$139 billion and government expenditures for Medicare and Medicaid alone were over \$38 billion.

UMC Scientist Gets EPA Contract

A University of Mississippi Medical Center research scientist has been awarded a four-year, \$397,429 contract from the United States Environmental Protection Agency.

Dr. Ben H. Douglas, UMC associate professor of medicine (research) and associate professor of physiology-biophysics, is studying the influence of elements found in hard and soft waters on the development of cardiovascular disease.

"We already know from previous studies that there is an inverse relationship between hard water and cardiovascular disease," Dr. Douglas said. "People who drink hard water, or live in hard water areas, are apparently less likely to have cardiovascular disease."

Dr. Douglas also said past studies indicate changing the mineral content of the vessel wall can change the rate of arteriosclerosis.

The UMC scientist will vary six minerals (calcium, cadmium, lead, magnesium, potassium and sodium) in the drinking water of normotensive and hypertensive rats to determine which mineral or minerals may protect against cardiovascular disease and which may promote it.

"Some of the rats, in addition, will be on a normal diet and some on an atherogenic diet," he said. "There may be some mineral combinations which may alter the process of arteriosclerosis."

AMA Urges Review of TV Violence

Richard E. Palmer, M.D., president of the AMA, has asked the leaders of 10 major corporations to review advertising policies that support TV shows containing the most prime time violence.

"TV violence is a mental health problem and an environmental issue," the AMA president said. "If the programming a child is exposed to consists largely of violent content, then his perceptions of the real world may be significantly distorted and his psychological development may be adversely affected."

Dr. Palmer also called upon the television networks to reexamine their policies regarding violence. "TV has been quick to raise questions of social responsibility with industries which pollute the air. In my opinion, television through its access to air waves

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INVESTMENT OF A FEW MINUTES

Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

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WHEN A HEARING
AID WILL HELP



WHEN
BURNING PAIN
COMPLICATES
ACUTE
CYSTITIS*

TURN IT OFF WITH
AZO GANTANOL[®]

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

FOR THE PAIN

- Quickly relieves painful symptoms such as burning and pain associated with urgency and frequency.
- Recommended antibacterial therapy: up to 3 days with Azo Gantanol, then 11 days with Gantanol (sulfamethoxazole).

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura,

FOR THE PATHOGENS

- Effectively controls susceptible pathogens such as *E. coli*, *Klebsiella-Aerobacter*, *Staph. aureus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

*nonobstructed, due to susceptible organisms

hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); G.I. reactions (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); CNS reactions (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. **Usual adult dosage:** 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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DYAZIDE[®]

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Each capsule contains 50 mg. of Dyrenium[®] (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with

cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy. Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium[®] (triamterene, SK&F Co.), and

leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
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and caffeine, 32 mg.



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c̄ CODEINE
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Each tablet contains:
codeine phosphate, 30 mg (gr ½),
(Warning: May be habit-forming);
and acetaminophen 300 mg.



Wellcome

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North Carolina 27709

may be creating a more serious problem of air pollution."

According to Dr. Palmer, "the American people should be concerned with the types of values and role models the media is presenting to a vast, youthful audience whose perceptions of society and reality and whose value systems are clearly in early development."

The corporations contacted by the AMA are: General Motors (Chevrolet Division); American Home Products (Whitehall Labs-Anacin); American Motors Corporation; Sears, Roebuck and Co.; Eastman Kodak Company; Joseph Schlitz Brewing Company (Schlitz Beer); Procter & Gamble Company (P & G Soaps); General Foods Corporation; Burger King Corporation; and Pepsico, Inc. (Frito-Lay Products).

Dr. Palmer has also sent letters to those corporations sponsoring programs containing the least amount of violence in network prime time television expressing the hope that their current policies would continue. They include: Peter Paul, Inc.; Hallmark Cards, Inc.; Texaco, Inc.; Whirlpool Corporation; Prudential Insurance Company of America; Squibb Corporation (Jean Nate products); Kusan Corporation (Schaper Toys); Green Giant Company; Keebler Company; and Carnation Company (Carnation Dog Foods).

Medical Center Sponsors Intensive Course



Physicians learned about drug therapy, outpatient counseling, and how to use the family as a therapeutically in the two and one-half day psychiatry intensive course at the University of Mississippi Medical Center. Dr. David Foy (center left), assistant professor of psychiatry (psychology), was one of the course instructors. Participants included Dr. Edgar E. Bobo of Pearl (left), Dr. John M. Estes of Hollandale, and Dr. J. D. Schmidt of Bude.

Comprehensive Medicine Institute Scheduled

The Institute for Comprehensive Medicine will hold a two-day seminar on April 2-3, 1977, at Sheraton-Houston Hotel, Houston, TX and on May 7-8, 1977, at MGM Grand Hotel, Las Vegas, NV.

Topics to be covered will include clinical hypnosis and behavior modification. Speakers are William S. Kroger, M.D., and William D. Fezler, Ph.D.

For information write Ms. Karnie Starrett, 10840 Queensland St., Los Angeles, CA 90034.

Dying Patient's Wishes Get Priority

Most physicians try to respect the wishes of a dying patient who doesn't want extraordinary measures used to prolong the last spark of life, even though the doctor's legal and ethical position is sometimes not clear, according to an American Medical Association poll of physicians.

The doctors were asked:

"Let's say a patient is terminally ill and has expressly indicated that no extraordinary measures be used to keep him alive when death is imminent. Since all the legal and ethical issues involved are not yet completely resolved, what do you think is the best course for the physician to follow?"

Responses varied, but most physicians surveyed seemed to feel that when a patient has made a "no intervention" decision, a doctor should respect it, providing minimal support care and making the patient as comfortable and free from pain as possible.

Many physicians, however, say that this course of action should be pursued only after a thorough discussion with the patient and his family, and only after the decision is carefully noted in the record. A few doctors say they would seek legal counsel or seek guidance from other non-involved physicians.

The real dilemma arises, some doctors say, when a patient wants to be allowed to die and his family wants every measure used to keep him alive. There were no good answers to this situation.

More than three-fourths of the poll respondents say they do discuss imminent death with terminally ill patients who are able to respond. They explain options and inquire about a patient's wishes regarding medical care during a terminal illness. Some 94.5 per cent of the respondents say they try to adhere to the patient's wishes.

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, Miss. 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white bond paper with a standard typewriter. **Brief manuscripts will be given preference.**

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly),

and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for up to four illustration engravings. More are not permitted unless voted on by two editors and extra costs must be absorbed by the author.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*



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IN CONCLUSION

No single law, regulation or policy "can hope to deal with the tremendously varied and complex issues of citizen rights in health record-keeping," according to a federal study on the dangers of computerizing health records. Computers, Health Records, and Citizen Rights calls for a "mosaic of policy actions" to accomplish the balance between collecting needed information and assuring there will be no unfair use of it. AMA's model bill on confidentiality was cited as "representing an excellent starting point for discussion."

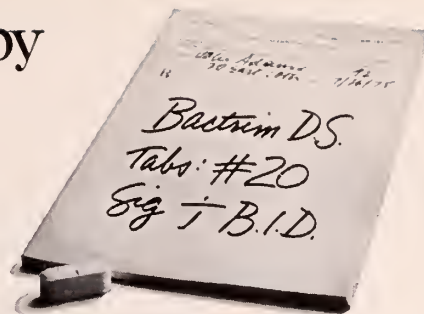
Resigning from the Ford Foundation Board of Trustees, Henry Ford II said: "The foundation exists and thrives on the fruits of our economic system. The dividends of competitive enterprise make it all possible. A significant portion of the substance created by U.S. business enables the foundation and like institutions to carry on their work. In effect, the foundation is a creation of capitalism -- a statement that, I'm sure, would be shocking to many professional staff people in the field of philanthropy."

The federal health planning act "demonstrates contempt" for state and individual rights and is "a radical departure from the American system of government," AMA stated in a 76-page brief challenging the constitutionality of the 1974 law. Also attacking the planning law in a federal court in North Carolina are the state of North Carolina, North Carolina Medical Society and the state of Nebraska. Defending the act are HEW secretary, American Association for Comprehensive Health Planning, Inc. and National Association of Neighborhood Health Centers.

Stepfathers are as effective as natural fathers in their roles as parents, and stepchildren are as happy as children who reside with their natural fathers, according to a study of "Stepfathers and the Mental Health of Their Children," by Western Behavioral Sciences Institute, La Jolla, CA. The children viewed themselves as just as happy as those reared by both natural parents and they were found to be just as successful and achieving. However, stepfathers rated themselves poorly, despite high marks given them by their stepchildren and wives.

A new definition of alcoholism has been announced by the joint National Council on Alcoholism/American Medical Society in Alcoholism Committee on Definitions. Full text of the definition appeared in the December Annals of Internal Medicine, publication of the American College of Physicians. The definition is: "Alcoholism is a chronic, progressive, and potentially fatal disease. It is characterized by tolerance, and physical dependency, pathologic organ changes, or both, all of which are the direct or indirect consequences of the alcohol ingested."

10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions noted in this study were mild (e.g., vomiting, nausea, rash), more serious reactions can occur with these drugs. See manufacturer's product information for complete listing. Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris* and *Proteus morganii*.

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprolthrombinemia and methemoglobinemia. *Allergic reactions:* Erythema

multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored—bottles of 16 oz (1 pint).



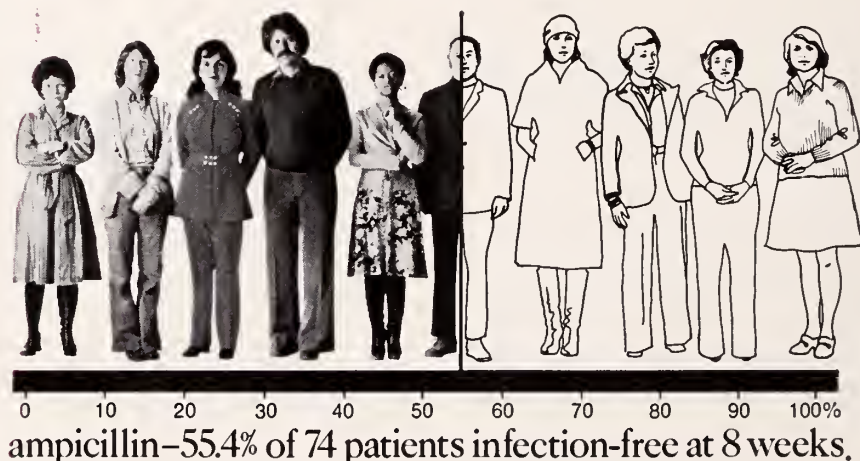
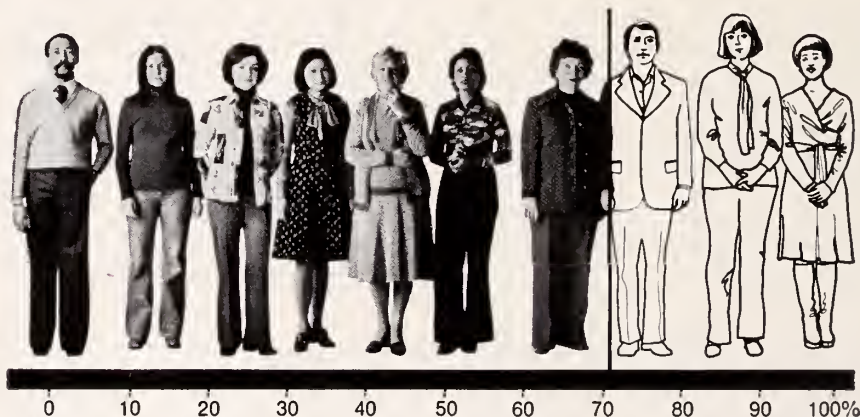
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*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets Just 1 tablet B.I.D.

Please see summary of product information on preceding page.

ROCHE

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

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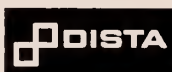
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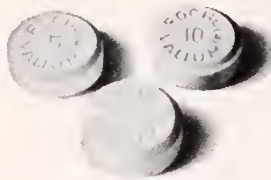
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Valium (diazepam) is a benzodiazepine with a character all its own.

Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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**a prudent choice in psychic
tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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M.D. Vacancies in Project USA Announced

Project USA, the American Medical Association's program to recruit physicians for short-term service (usually two weeks) has year round vacancies at Indian Health Service facilities, and National Health Service Corps rural communities. Project USA physicians receive \$500 a week plus round trip air coach fare, and family housing accommodations are provided.

Malpractice insurance coverage is furnished under the Federal Torts Claims Act for service on Indian reservations; however, the physician must provide his/her own malpractice insurance at a NHSC site. It is a simple procedure to extend existing coverage to include short-term service at a NHSC location. Any expense involved in this process will be assumed by Project USA.

Physicians interested in participating in this program are requested to contact John Naughton, AMA, 535 N. Dearborn, Chicago, IL 60610; (312) 751-6388.

Juvenile Diabetes Film Is Available

The Greater Jackson Chapter of the Juvenile Diabetes Foundation has placed in the film library of the Mississippi State Board of Health the film, "Low Blood Sugar Emergencies in the Diabetic Child." This film was produced in conjunction with a major school system and a county health department. It is appropriate for general, lay audiences, including school personnel (teachers, administrators, clerical staff, coaches, nurses, bus drivers); parents of new diabetics; police, fire and rescue squads; camp counselors; scout, church and other youth leaders. It is also recommended for various medical, paramedical, and educational staff training programs.

The film may be scheduled for use by contacting: Film Library, Mississippi State Board of Health, P. O. Box 1700, Jackson, MS 39205.

For diabetes information, write to: Greater Jackson Chapter, Juvenile Diabetes Foundation, 333 North Mart Plaza, Jackson, MS 39206, or call 366-4400.

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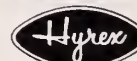
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Volume XVIII

Number 4

April 1977



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$15.00 per annum; \$2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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RECENT CHANGES

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special report
**Malpractice
insurance:**

**drug
bulletin**

Health care doesn't
need more red tape

Drug firms challenge
'MAC' rules

**Drug
Substitution**

The Consensus Determinant
of Health Progress is
RESEARCH

Mailgram 2

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



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Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
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Final classification of the less-than-effective indications requires further investigation.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls

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Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

NEWSLETTER

April 1977

Dear Doctor:

The probable cause of the "Legionnaires' Disease" is a "bacterium-like organism," so far unnamed. Further study of it may lead to a new understanding of certain types of pneumonia, according to scientists at the Center for Disease Control in Atlanta. The organism also may be the pathogen involved in the "unsolved" 1966 epidemic of a pneumonia-like illness at St. Elizabeth's Hospital in Washington, DC, where 94 patients became ill and 16 died.

Early tests have shown evidence of antibodies to the new microbe in 13 or 14 samples of frozen sera from these patients. Epidemiologists have returned to Philadelphia in search of new associations between the new organism, environmental conditions, and patterns of illness.

Four medical schools have stated publicly they will refuse federal capitation assistance rather than be forced to accept U.S. citizens from foreign medical schools. The four schools planning to oppose the forced-transfer provision of the new health manpower bill are Indiana University, Yale University, Stanford University, and Wright State University in Dayton, Ohio.

In a 27-page decision, a New York State Supreme Court Justice ruled that a 58-year-old derelict, whose gangrenous leg had been scheduled for amputation, had the right to refuse to undergo the operation. Over objections from physicians, Justice H. G. Schwartz ruled the operation was not "life-saving" and that contrary to psychiatrists' findings, the invalid was competent to decide his own fate.

Beta Gonorrhea, caused by a new strain totally immune to the effects of penicillin, has public health officials worried. More than 50 cases have been detected in the U.S. Center for Disease Control is urging all state and local health departments to make an extra effort to track down gonorrhea patients who aren't responding to penicillin and see that they are treated with spectinomycin.

The cost of having a baby has increased 40 per cent in five years, according to estimates of the Health Insurance Institute. The total cost of having a baby in the U.S. (which includes obstetrics and pediatric care, hospital room charges, clothing, vitamins and furniture) is \$2,194 today compared to \$1,600 in 1971. Life expectancy for baby boys is now 68.5 years and 76.4 years for girls.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

New Criteria Listed For Brain Death

Criteria for determining when the brain is truly dead, even though machines may be keeping the heart beating and the lungs breathing, are listed in the March 7 *Journal of the American Medical Association*.

The National Institute of Neurological and Communicative Disorders and Stroke sponsored a study in which 503 patients were examined in nine medical centers.

The study concluded that establishment of cerebral death requires:

1. All appropriate examinations and treatment procedures have been performed.
2. The brain is completely unresponsive, breathing without the machines has stopped, pupils are dilated, reflexes such as blinking are missing, and the electrocardiogram is silent for 30 minutes at least six hours after the stroke or accident.
3. If one of these standards is met imprecisely or cannot be tested, a confirmatory test can be made to demonstrate the absence of blood flow in the brain.

The third rule would allow the diagnosis of a dead brain to be made in patients with small amounts of sedative drugs in the blood, in patients undergoing treatment procedures that make examination of cranial nerves impossible, and in patients otherwise meeting the criteria but whose pupils are not dilated.

Project coordinator for the study was A. Earl Walker, M.D., of the University of New Mexico School of Medicine, Albuquerque.

The state known as brain death came to the attention of physicians and the public some years ago when transplant surgery gained popularity. Viable organs were needed for transplant. If the pronouncement of death was delayed until the heart stopped beating, the organs underwent so much deterioration that a successful transplant was jeopardized, Dr. Walker points out.

Dr. Walker distinguishes between brain death and irreversible coma. Brain death means total destruction of the brain. Irreversible coma refers to a vegetating state in which all functions attributed to the brain are lost, but certain vital functions, such as respiration, temperature and blood pressure regulation may be retained.

Legal statutes in a number of states recognize brain death but not irreversible coma as a means of certifying death.

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CH-GP-51-4/C

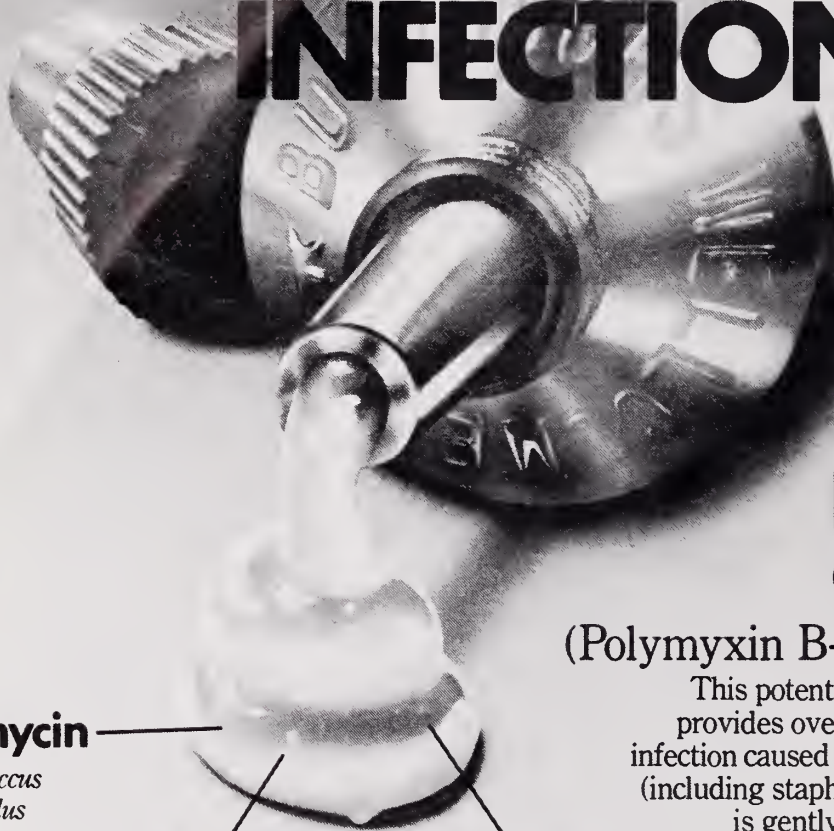


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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Private Health Insurance Grows

Private health insurance is registering solid growth in both quality and quantity.

As 1977 began, some 87 per cent of the population—an estimated 183 million Americans had some form of private health insurance. In 1970, 80 per cent had it; in 1960, 70 per cent; in 1950, 51 per cent; in 1940, 9 per cent.

Protection against catastrophic health care expenses was being provided to an estimated 149 million Americans at the start of 1977, with major medical plans of insurance companies protecting 93 million.

Significantly, 83 per cent of those with private health insurance now have coverage providing protection against major health costs. This ratio had grown from 22 per cent in 1970 and 61 per cent in 1970.

Try This Riddle . . .

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Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povon. Care should be exercised not to spill the suspension because it will stain most materials.

Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions:

Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povon Suspension than with Povon Filmseals.

How Supplied: Each Povon Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povon Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

RC/RD PD JA 1699-2 P (8 76)

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DATELINE

Drug Companies Have
Paperwork, Too

Washington, DC - Richard D. Wood, board chairman of Eli Lilly and Co., testified before President's Commission on Federal Paperwork: "Our company prepares 27,000 government forms or reports a year at a cost of \$5 million...All the necessary analysis and background work is conservatively estimated at another \$10 million. If this total of \$15 million was theoretically applied only to our U.S. pharmaceutical business, it added approximately 50 cents to the price of every prescription..."

Are Health Records
Confidential?

Denver, CO - A Denver-based firm recently indicted for stealing medical records and selling them to life insurance companies represents "only the tip of a nationwide iceberg,"

according to A. F. Freedman, M.D., head of National Commission on Confidentiality of Health Records. The Denver concern -- Factual Services Bureau, Inc. -- had offices in 15 cities and allegedly used a variety of fraudulent methods, such as impersonating MDs, to obtain health and medical records.

Americans Learn to
Cope with Stress

Seattle, WA - One indication that Americans have learned to live with the stress of urbanization is that there are fewer ulcers, M. P. Smith, M.D., of the University of

Washington School of Medicine reports in JAMA. Incidence of duodenal ulcer began declining around 1955 and has continued for 20 years, said Dr. Smith. Since societal stresses have not diminished, it is assumed that people have now adapted to industrial society demands.

Men Still Weigh More
and Are Taller

Washington, DC - A study recently released by the Department of HEW shows that men generally weigh 6 lb. more and are .7 in. taller than in 1960. Women are 3 lb. heavier and

.5 in. taller, according to statistics gathered from 1971-74 on men and women aged 18-74. Although these are not necessarily ideal weights, the typical American male stands 5 ft. 9 in. and weighs 172 lb. The typical woman is 5 ft. 3.6 in. and weighs 143 lb.

Social Welfare
Spending Is High

Washington, DC - The Department of HEW says that during fiscal 1976, social welfare programs cost the nation's taxpayers \$331 billion -- or \$45 billion more than they

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The Wangenstein Surgical Symposium will be held June 9-11, 1977, at the University of Kentucky Medical Center, Lexington. Registration fee is \$200.00.

For further information, contact: Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

Humanities Seminars for Doctors Announced

The National Endowment for the Humanities announces four one-month humanities seminars for physicians and other members of the health professions to be held in the summer and fall of 1977. Members of the medical profession will be brought together with humanists from the fields of philosophy and religion for the month of fulltime study which will be devoted to such issues as ethical conflicts, the rights of patients and practitioners, and health delivery.

Two additional seminars open to health professionals will bring them together with leaders from the fields of law, public administration, school administration, business, and labor to study value conflict and the ethical dimension in contemporary society.

Up to 15 participants will attend each seminar tuition free and will receive a \$1,200 stipend to cover expenses, plus reimbursement for travel up to a \$300 maximum. Participants may be accompanied by members of their families, but the stipend will not be increased.

Further information, including a leaflet describing the seminars in detail and application forms, may be obtained from:

Professor James F. Childress, Center for Bioethics, Kennedy Institute, Georgetown University, Washington, D. C. 20057

Professor H. Tristram Engelhardt, Jr., Institute for the Medical Humanities, University of Texas Medical Branch, Galveston, TX 77550

Professor John Lachs, Box 12, Station B, Vanderbilt University, Nashville, TN 37235

Professor William F. May, c/o Linda Bernstein, The Poynter Center, Indiana University, 410 North Park, Bloomington, IN 47401

Professor John E. Smith, Clark Professor of Philosophy, 1562 Yale Station, New Haven, CT 06520

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Jackson Room, Sheraton-Biloxi

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A cocktail party will follow the seminar. All registrants are invited to attend.

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Full information is available on request.

Health Planning Is Extended

A one-year extension of the health planning law has been approved by the House Commerce Health Subcommittee. Subcommittee Chairman Paul Rogers (D-Fla.) said he intends to pass simple extensions for most of the federal health programs scheduled to expire this year. Full-scale reviews will be held next year.

However, the subcommittee made some changes in its one-year extension of the Health Manpower Law, including a one-year delay in the requirement that foreign medical graduates pass equivalency exams.

Medicaid Controls Are Criticized

Legislation aimed at "Medicaid Mills" would overshoot the mark and stigmatize practically all group practices, the AMA told a joint hearing of the House Commerce and Ways and Means Subcommittees on Health.

Edgar T. Beddingfield, Jr., M.D., chairman of the AMA Council on Legislation, said the Medicare-Medicaid Anti-Fraud and Abuse Amendments (HR 3) proposal is "not simply an attempt to control 'Medicaid Mills' but rather authorization to investigate the action of almost every practicing physician in the country."

Under the bill, all practicing physicians who render Medicare and Medicaid services would be subject to PSRO review of outpatient services.

Medical Assistants Offer Med. Terminology Course

The Central Chapter, Mississippi Society, American Association of Medical Assistants will sponsor a medical terminology course, on Monday nights, April 11-June 27 at the Mississippi Methodist Rehabilitation Center, located on the UMC campus in Jackson.

Cost is \$35.00 per person and includes textbook. Instructor is Dr. Ben Clower, associate professor of anatomy, UMC.

Make checks payable to AAMA-MS-Central Chapter and mail to Carol Baxter, Educational chairman, 1585 Raymond Rd., Jackson 39204. For information call central president Carol Lockey at 362-8663.

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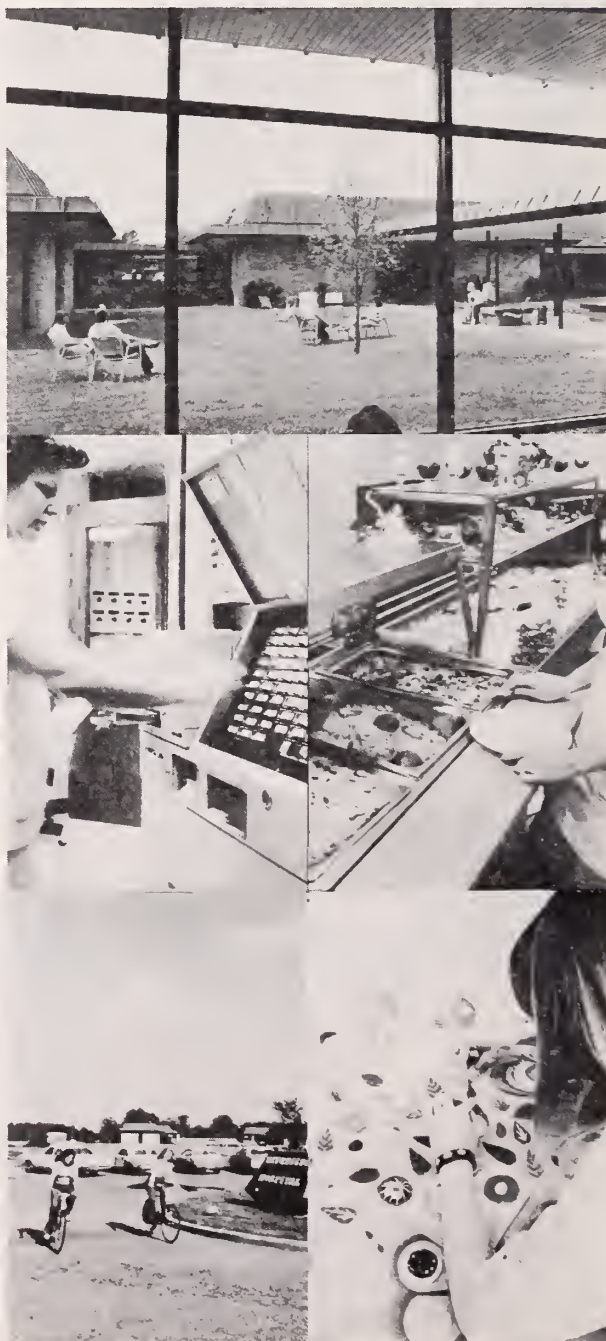
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ORIGINAL PAPERS

Survival After Cardiac Valve Replacement With a Porcine Xenograft—The Mississippi Experience

JEFFERSON F. HOLLINGSWORTH, M.D.

Jackson, Mississippi

ADDENDUM

Since this paper was submitted for publication, Dr. Henry B. Tyler and I have performed valve replacements on an additional 66 patients. Thirty-one (0) patients had aortic valve replacements, 25 (1) mitral valve replacements, and 10 (1) aortic and mitral valve replacements (deaths in parentheses). The combined operative mortality for the entire patient population (116) is 3.4 per cent. To this date, there are no instances of valve failure.

OPERATIVE SURVIVAL following cardiac valve replacement has steadily increased over the past decade. Refinements in surgical technique and available prostheses have contributed to increased survival. This report reviews our experience here in Mississippi utilizing the Hancock porcine xenograft prosthesis for aortic and mitral valve replacement in 50 patients. The porcine xenograft used in this series is manufactured by Hancock Laboratories and consists of glutaraldehyde preserved porcine aortic valve mounted on a flexible polypropylene dacron covered stent. The methods for preparation of this xenograft prosthesis have been previously described in detail.¹

CLINICAL MATERIAL

The 50 patients undergoing valve replacement included 8 children, ages 6 to 15, average age 11; and 42 adults, ages 16 to 69, average age 41. Infants

Dr. Hollingsworth was formerly on the faculty of the University of Mississippi Medical Center. He is now in private practice (cardiovascular surgery) in Jackson.

under one year were excluded from this series. There were 22 males and 28 females. Twenty-one patients underwent aortic valve replacement with the porcine

Between May 1975 and March 1976, 50 patients underwent aortic and mitral valve replacement with a porcine xenograft heart valve. Operative survival was 96 per cent (48 patients). Operative survival in scheduled non-emergency operations was 100 per cent (46 patients). The functional class (New York Heart Association) of this patient group improved from a mean preoperative class of 3.2 to a mean postoperative class of 1.8. No systemic thromboembolism or valve failures have occurred. We conclude that this xenograft prosthesis provides a functionally satisfactory valve substitute and that the operative mortality has been reduced below previously reported statistics.

xenograft. The etiology of the aortic valvular disease was rheumatic in 16 patients, congenital in 2 patients, and Marfan Syndrome in 2 patients. Thirty-six mitral valves were replaced. The etiology of mitral valvular disease was rheumatic in 31 patients (see Figure 1). Eight patients had disease involving both the aortic and mitral valves, requiring double valve replacement. Thirty-one of the 50 patients had been in uncompensated congestive heart failure within six months prior to operation. Fourteen

VALVE REPLACEMENT / Hollingsworth

of the 50 patients were in atrial fibrillation preoperatively. The preoperative functional classification averaged 3.2 with 17 patients classified as Class IV and 28 patients Class III status. Preoperative catheterization data revealed that cardiac pressures were substantially elevated. The mean right ventricular systolic pressure was 57 with a mean right ventricular end diastolic pressure of 8. Pulmonary hypertension was present in 40 of the 50 patients operated on with a mean pulmonary artery pressure of 56. The highest pulmonary artery pressure recorded in the series was 120 millimeters of mercury.

Mean pulmonary artery wedge pressure reflecting left atrial pressure was elevated with a mean value of 21 millimeters of mercury. Left ventricular end diastolic pressure indicative of depressed left ventricular function was also elevated with a mean value of 16 millimeters of mercury. Two patients had a left atrial thrombus and 15 patients had calcification present in the aortic or mitral valve rings. Nine of the 50 patients had previous cardiac valve replacements and were reoperated on for prosthetic dysfunction.

METHODS

Standard techniques for cardiopulmonary bypass utilizing a disposable bubble-type oxygenator were employed. All operations were performed through a median sternotomy. Aortic cross clamping was utilized combined with local hypothermia induced by continuous irrigation of the pericardial sac with cold saline at 4 degrees centigrade. This technique was used for both aortic and mitral valve replacement. Coronary perfusion was not used for any

ETIOLOGICAL CATEGORIES OF CONDITIONS REQUIRING VALVE REPLACEMENT IN 50 PATIENTS

Group	No. of Patients
I. R H D	34
II. Myxomatous Degeneration	5
III. Ruptured Chordae	4
IV. Congenital	4(1)
V. C M N	2
VI. Traumatic	1(1)

RHD - Rheumatic Heart Disease

CMN - Cystic Medial Necrosis

(Deaths in parenthesis)

Figure 1

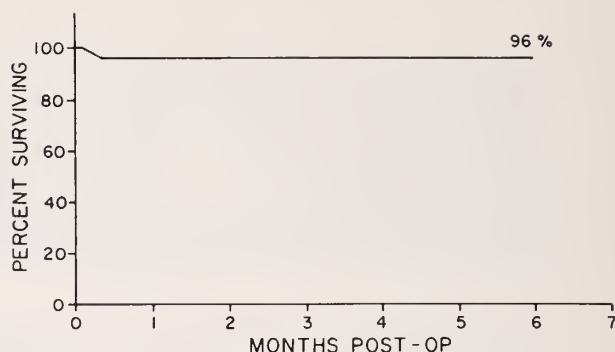


Figure 2. Survival curve demonstrating a 96 per cent operative survival six months following valve replacement.

operations in this series. No Coumadin or Heparin was used in the postoperative period.

Current follow-up of all discharged patients was obtained by direct contact with the patient. Functional classification was assigned according to the New York Heart Association criteria on the basis of current symptoms.

RESULTS

Operative Mortality—Two of the 50 patients died within 30 days of operation (4 per cent operative mortality). The remaining 48 patients are all surviving at this time (96 per cent survival) (see Figure 2). Four of the 50 patients were surgical emergencies and non-scheduled operations. The remaining 46 patients were electively scheduled for operation. All 46 patients electively scheduled for operation survived (elective mortality 0.0 per cent). These 46 patients included 7 patients undergoing aortic and mitral valve replacement, 9 patients having replacement of existing cardiac valves, and 7 valve replacements in children less than 15 years of age. Both deaths in the series were from the group of 4 patients having emergency operations. The first death occurred in a patient who sustained blunt trauma to the chest, which ruptured the mitral and tricuspid rings and produced a dissection of the ascending aorta. The dissection of the aorta was unrecognized until the operation was underway. The patient was in pulmonary edema during induction of anesthesia and did not separate from cardiopulmonary bypass following double valve insertion and repair of the aortic dissection. The remaining death in this series was that of an 11-year-old boy with a ventricular septal defect and congenital aortic regurgitation, who had a previous closure of his ventricular septal defect and plication of his aortic valve, resulting in further progressive aortic regurgitation. He was operated upon as an emergency while in pul-

monary edema and did not separate from cardiopulmonary bypass due to left ventricular dysfunction.

Evaluation of the 48 patients surviving operation reveals that the average functional class is now 1.8 with 29 patients Class II and 12 patients Class I. This represents a marked functional improvement from the preoperative mean class of 3.2 (see Figure 3). None of the 48 surviving patients has sustained any systemic thromboembolizing episodes. No patients have evidence of valvular regurgitation or prosthetic dysfunction.

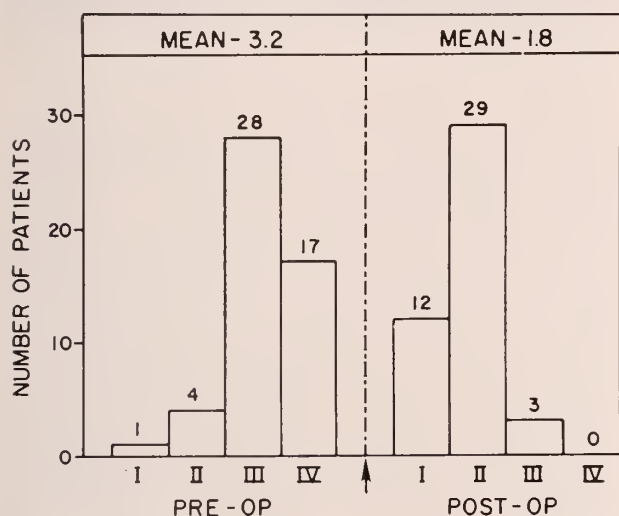


Figure 3. The figure demonstrates the functional improvement in our patient group following valve replacement (3.2 preoperatively to 1.8 postoperatively, N.Y.H.A.).

The average aortic valve size inserted was 25 mm and the average mitral valve size was 31 mm. Three patients had coronary artery bypass grafts performed during valve replacement with no mortality. Nine patients had evidence of ventricular irritability in the postoperative period marked by ventricular arrhythmias. No patients had evidence of third degree heart block and there were no pulmonary emboli. Forty-two of the 48 patients remain on Digoxin and 18 patients at this time are taking mild diuretics (Aldactazide). Six patients are maintained on antiarrhythmic drugs and no patients are currently anticoagulated.

COMMENT

Nationally reported statistics reveal that acceptable operative mortality for single cardiac valve replacement ranges from 5 to 15 per cent. Isolated mitral replacement mortality has been reported by Kirklin as 13.5 per cent;² Cooley 9.1 per cent;³ Spencer 8.7 per cent,⁴ and Shumway 4.9.⁵

Aortic replacement mortality has been reported by

Cooley as 7.4 per cent;³ McGoon 6.5 per cent,⁶ and Bjork 5 per cent.⁷

Although our series is relatively small, it does reveal a total mortality of only 4.0 per cent and no operative deaths in 46 patients undergoing elective valve replacement, be it aortic, mitral, or double valve replacement. The two deaths in this group of 50 patients occurred in emergency situations.

The improved operative mortality noted in this series (4.0 per cent total, 0.0 per cent elective) may be a result of a uniform approach to operative techniques and postoperative care but also may reflect the favorable hemodynamic characteristics of the porcine valve. Because of the central flow design of the valve, there is a large effective orifice area reducing transvalvular gradients and cardiac filling pressures.

In addition, the large effective orifice area means that valve replacement can be performed in a small child and the valve will continue to be adequate in size in spite of normal growth and development. This porcine valve is associated with a very low incidence of thromboembolism and patients are not required to take Coumadin following valve replacement.

Over 20,000 of these porcine xenografts have now been implanted and five year follow-up studies have revealed no valve failures. The durability and long term function of this valve are its most critical unanswered questions. However, its immediate results and function seem excellent. ★★★

1600 North State Street (39202)

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Radiologic Seminar CLXIX: Massive Adenocarcinoma of the Lung With Local Control by Irradiation and Adjunctive Medication: A Case Report

R. ARNOLD SMITH, M.D.
Jackson, Mississippi

THIS 69-YEAR-OLD black brick mason was seen by his family physician with increasing fatigue, dyspnea, and right chest pain. In addition, there was a soft tissue mass over the anterior superior aspect of the right chest. Chest x-ray (see Figure 1) revealed a massive rounded pulmonary density occupying the entire right upper lung field and encroaching on the mediastinum. After referral to this institution, biopsy of the anterior chest wall lesion revealed a well differentiated papillary adenocarcinoma (see Figure 2) compatible with pulmonary origin. Metastatic work-up was negative except for the disease described above. The patient was referred to the Department of Radiation Therapy for initial treatment of this disease. The assessment of the patient's case at presentation was that the massive pulmonary lesion was an unusually significant initial problem, and that poor local control with this often relatively radioresistant tumor would result in such marked disability to the patient that systemic or distant control would become irrelevant. For a good functional state, persistent local control would be essential.

At that time we chose a problem of overall management to try to maximize the chance for local control of this relatively radioresistant tumor. The patient was anticoagulated with sodium warfarin (Coumadin) 25 mg. initially and subsequent doses were prescribed as required to keep the prothrombin time approximately 50 per cent of normal. The patient was also started on medroxyprogesterone acetate (Provera) 10 mg. P.O. three times daily, and ethinyl estradiol, .02 mg. P.O. three times daily. Large field irradiation to the primary tumor, the right hilar region, the mediastinum, and the supraclavicular regions bilaterally was started at the mid plane dose rate of 180 rads per day. Twice weekly

intravenous injections with 5-fluorouracil, 500 mg. were begun. Blood counts were monitored to assure a white count of greater than 2000, and a platelet count of greater than 100,000/mm³.

The patient's initial treatment course progressed uneventfully. An x-ray at 3780 rads revealed excellent regression. Field size reduction was carried out to avoid excessive buildup in the spinal cord, and to encompass a shrinking lesion. The total dose to the rounded lesion ultimately reached 6480 rads, at which time the patient developed a pneumonitis accompanied by malaise, cough and whitish sputum production. The patient was thought to have a radia-

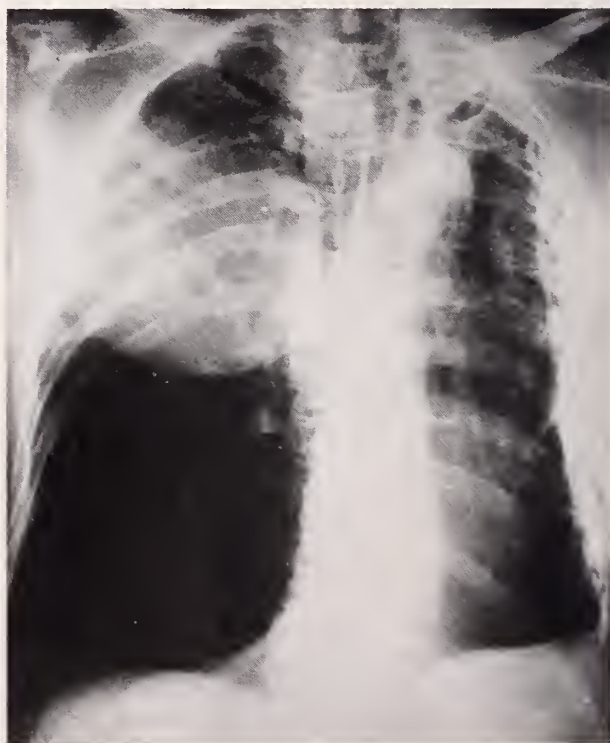


Figure 1. Patient's radiograph at presentation showing massive rounded lesion. Patient has old traumatic injury to left chest.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist
Medical Center, Jackson, MS.



Figure 2. Photomicrograph of well differentiated papillary adenocarcinoma.

tion pneumonitis, and he was started on a brief course of prednisone, 5 mg., twice daily. On this regimen his pneumonitis symptoms cleared rather rapidly. A chest x-ray taken two weeks after completion (see Figure 3) showed further and very excellent regression. The patient was then referred for multiple drug chemotherapy with Adriamycin, cyclophosphamide, and 5-fluorouracil. An x-ray taken almost four months after completion (see Figure 4) demonstrated only minimal residual scar and no obvious residual tumor. The patient died of disseminated disease 15 months after starting irradiation with no evidence of chest recurrence at that time.



Figure 3. Radiograph two weeks after completion showing excellent regression.

DISCUSSION

There is growing evidence that the macrophage plays an important cytotoxic role in the surveillance mechanism by which the host defends itself against foreign invaders, including neoplastic cells. Excellent time lapse photography movies at the American Society for Therapeutic Radiology meeting this year showed macrophages in tissue culture which clearly destroyed cancer cells if they could maintain direct cellular contact for a suitable length of time. Recent experimental work indicates that activated macrophages can release a humoral factor specific against tumor cells.⁷ Macrophages can also sensitize T-lymphocytes to tumor antigens.²¹ There is strong evidence¹⁶ on experimental grounds that estrogens can stimulate the phagocyte system to increased activity. There is evidence⁴ on clinical grounds that estrogens decrease the overall incidence of cancer, although the causal implication in endometrial cancer appears incontrovertible. Estrogens can also reduce complications in heavily irradiated mucosal surfaces.¹⁰ Whether estrogens can be used to counteract the temporary immunoincompetence¹⁷ resulting from cobalt irradiation of solid tumors is uncertain, but an effective supportive measure for host immune mechanism would certainly be a useful tool.



Figure 4. Radiograph four months after completion showing only minimal residual hilar scar. A hazy radiation fibrosis is now seen in the right upper lung field.

It is a well documented observation in the cancer treatment literature that adenocarcinomas of renal² and endometrial¹⁸ origin may respond to hormones of the progesterone-testosterone group. Favorable data has been reported³ on the adjuvant use of progesterone with irradiation in endometrial carcinoma. It has been this author's observation that adenocarcinoma of the lung also responds to hormonal manipulation with a frequency justifying therapeutic trial. The mechanism for progesterone hormonal effect appears unclear, and an explanation implicating solely a direct action on the neoplastic cell by the progesterone appears to be an oversimplification.

If lung cancer patients are divided according to extent of weight loss at presentation, a markedly lower prognosis is noted in those patients having lost greater than 12 per cent of their usual weight.¹³ Immune competence is closely correlated with nutritional status.^{5, 11, 14} Reversal of the progressive cachexia of neoplasia undoubtedly is one of the most important contributions of anabolic hormones.

THROMBOEMBOLIC COMPLICATIONS

A substantial number of patients treated with adenocarcinoma of the lung at this institution have in the past developed thromboembolic complications during treatment, and adenocarcinoma of the lung should be grouped with pancreatic adenocarcinoma²⁰ as a malignancy with a high risk for thromboembolic complications. The highest malignancy associated thrombocytosis ($6,000,000/\text{mm}^3$) yet reported was recently described in adenocarcinoma of the lung.¹⁹ There is also a considerable volume of evidence¹² that increased coagulability of blood may often play an important pathophysiologic role in the preservation and propagation of a viable malignancy. Those cellular mutations which are able to survive the body defenses and proliferate as solid cancers appear to be capable in many cases of surrounding themselves with a fibrin shell which prevents the contact cytotoxic cells such as the phagocyte from satisfactory function. Cancers which have evolved this type of pathophysiologic adaptation can spread by pushing a fibrinous protective shell before them as they expand through normal tissues. There is good clinical evidence⁸ that anticoagulation can be used effectively as an adjunct to chemotherapy. There is also interesting evidence¹ that adenocarcinoma of the lung produces a characteristic tumor specific antigen often in large quantity. That this antigen might be a powerful coagulogenic agent, either acting directly or

through indirect thrombocytosis, is not an unreasonable hypothesis.

Several cytotoxic chemical agents have been used as irradiation adjuvants with slight improvement in success rates. Probably the most widely reported is 5-fluorouracil.^{5, 15}

Microbacterial infection is an attack on host integrity which, like cancer, is carried out by cellular proliferation of an uncontrolled nature. It has become very common in the antibiotic therapy of microbial invasion for multiple drugs to be used, especially when the sensitivity characteristics of the invader are not definitely known. This author can remember a time when use of more than one antibiotic was derogatorily described as "shotgun therapy." One seldom hears that type of irrational criticism today. A shotgun continues to be a very effective weapon.

The search for effective management programs in malignant disease demands constant vigilance by the physician for modalities which might be employed additively in a total therapeutic approach. In a fashion analogous to antimicrobial therapy, multiple drug chemotherapy has proven itself almost universally more effective than single drug management in cancer treatment. Multiple drug cytotoxic chemotherapy is now the mainstay of the life saving medical advances which make acute lymphocytic leukemia, rhabdomyosarcoma, and Ewing's sarcoma curable diseases. The basis for multiple drug chemotherapy is summation of antineoplastic activities but non-overlap of normal tissue toxicities. In malignancies now proved curable, many earlier trials of single agent chemotherapy proved only transiently beneficial.

The search for useful adjuncts to ionizing irradiation is an area of intense interest today. It appears that the adjunctive use of the cytotoxic agents of conventional chemotherapy must be very conservative in most cases, as the soft tissue side effects are often additive just as are the tumor killing effects. Such agents as hormones, vitamins, and anticoagulants have perhaps more promise since the modalities of toxicity with these agents do not overlap with that of irradiation, and a safe summation of activities can be hoped for on theoretical grounds. Today there are available pharmacologic agents which have very minimal risk in clinical use, and which together constitute a very fertile area for useful therapeutic exploration, as the risk versus gain considerations for the patient make clinical use of these agents much more acceptable than direct cytotoxic chemotherapy. Put another way, there is room for valid clinical exploration

without violating the axiom of *primum non nocere*. In radiotherapy patients multiple drug adjuvant non-cytotoxic chemotherapy is probably a more fertile field than the adjunctive use of cytotoxic chemotherapy (alkalating agents, antimetabolites, etc.) of the more popular and conventional type. Emphasis on agents which stimulate host immune defenses (anabolic hormones, glucan, BCG) disrupt tumor defenses (anticoagulants, Vitamin C), or increase normal tissue tolerance (estrogens) appears justified, since a potential for major future advances in radiotherapy management appears to lie in this area.

This particular case illustrates the best regression which this author has seen in a bulky well differentiated adenocarcinoma of lung origin. Whether this case illustrates effective adjunctive use of medication is open to conjecture, but one cannot avoid the conclusion that local control for this extremely large and well differentiated tumor was exceptionally successful.

★★★

Suite 609, 1151 North State Street (39201)

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New JOURNAL MSMA policy allows only 10 references to be published. The author will furnish a complete list of references (21) on request.

April 26, 1977

MISSISSIPPI THORACIC SOCIETY ANNUAL MEETING
University Medical Center, Jackson

Sponsored by the Mississippi Thoracic Society, Mississippi Lung Association, University of Mississippi School of Medicine and University Medical Center Division of Continuing Health Professional Education.

Coordinator:

Richard T. Furr, M.D., Ocean Springs.

Annual business meeting and scientific session.

Fee: \$15. Credit: 6 contact hours, .6 CEU, Category 1, AMA, AAFP.

MSMA Tennis Tournament

Register Now!



Wednesday Afternoon,
May 4, 1977

Beginning at 2:00 p.m.
Biloxi, MS

Men's and Women's
Doubles

Chairman: Dr. Henry B. Tyler, Jackson (Telephone 948-1411)

Mail form below to Dr. Tyler, c/o MSMA, P.O. Box 5229, Jackson 39216

I would like to register for the MSMA Tennis Tournament:

Name

Address

More details will be published in the MSMA Blue Sheet and will be available at MSMA Registration, Sheraton-Biloxi.

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INVESTMENT OF A FEW MIN

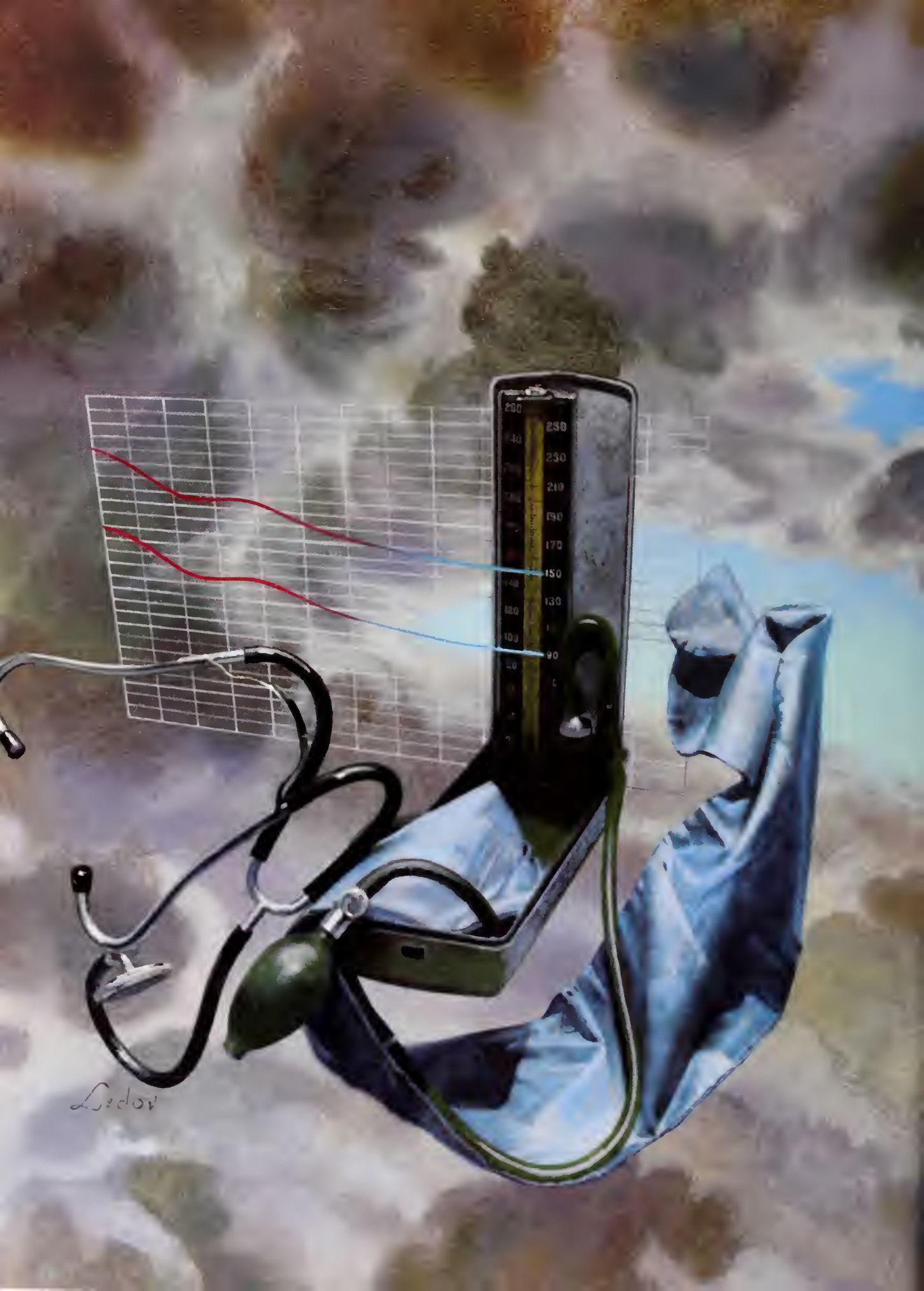
Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

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WHEN A HEARING
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When choosing a diuretic for day-in-day-out hypertension control with comfortable compliance...

The agent you choose in mild to moderate essential hypertension should offer (1) long-term effectiveness, (2) patient comfort and compliance.

Zaroxolyn offers both.

In one long-term study¹ Zaroxolyn brought moderately elevated (average 161/109 mm Hg) blood pressure down to the range of normotension—and held it there for a year or more.

The investigator noted, "Patient cooperation was surprisingly good for a study of such duration [2½ years]. The once-daily dosage schedule with

metolazone [Zaroxolyn] no doubt contributed to patient compliance."

Overall compliance with Zaroxolyn is good—very good. An analysis of controlled clinical studies involving 188 Zaroxolyn patients showed that only eight discontinued therapy because of side effects. That's a discontinuation rate of only 4.3%, and broader clinical experience appears to substantiate this low rate?²

Zaroxolyn. For long-term control and comfortable compliance in mild to moderate hypertension.

Recommended initial dosage in mild to moderate essential hypertension—2½ to 5 mg once daily

Zaroxolyn[®]

(metolazone, Pennwalt)

2½-mg, 5-mg and 10-mg tablets

once-daily antihypertensive diuretic

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma, allergy or sensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing

age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, or other skin rashes, dryness of mouth,

hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg, edema of cardiac failure—5 to 10 mg, edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg

References:

- 1 Dornfeld L, Kane R. Metolazone in essential hypertension. The long-term clinical efficacy of a new diuretic. *Curr Ther Res* 18: 527-533, 1975
- 2 Data on file, Medical Department, Pennwalt Prescription Products

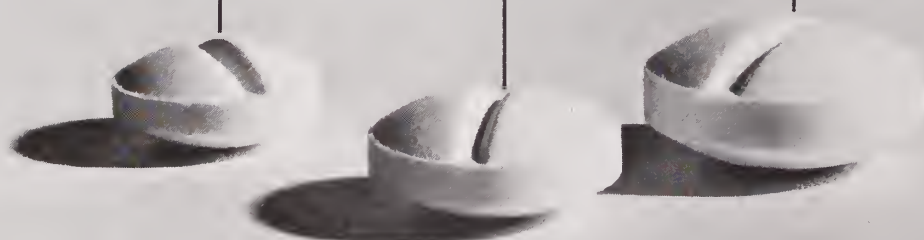
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109th Annual Session

Mississippi State Medical Association
May 2-5, 1977
Biloxi

THE SUNNY GULF COAST beckons Mississippi physicians and their families as the 109th Annual Session of the association gets underway May 2-5 at the Sheraton-Biloxi. Twelve scientific sections, fifteen specialty and related groups, three medical alumni social occasions, technical and scientific exhibits, the House of Delegates, and a host of fellowship events are slated for the five-day meet. (Meetings actually begin on May 1.)

Dr. Lyne S. Gamble of Greenville, association president, will address the opening meeting of the House of Delegates on May 2. House Speaker C. D. Taylor, Jr., of Pass Christian, and Vice Speaker R. Faser Triplett of Jackson said that delegates will receive their complete House of Delegates folders before May 2 for study prior to the convention. The opening session of the house will be limited to the address of the president, recognition and remarks of distinguished guests and introduction of reports and resolutions not received in time for inclusion in the delegates folder. Final action will come on May 5 when 1977-78 officers are also elected.

Dr. James O. Gilmore of Oxford will be inaugurated president for the new year during closing ceremonies on the final day.

Dr. J. Elmer Nix of Jackson, Council on Scientific Assembly chairman, said that the Scientific Assembly will open on Sunday afternoon, May 1, and continue through Wednesday afternoon. The Scientific Assembly has been approved for 14 hours of MAFP prescribed credit and 14 hours Category I credit toward the AMA physicians recognition award. A special postgraduate education opportunity is the Sunday afternoon seminar on genitourinary problems sponsored by the Mississippi Urological Society. Open to all but especially oriented toward family practitioners, the seminar is set for May 1 from 1 to 4:00 p.m. in the Jackson Room. Dr. Nix heads the group which has planned and scheduled the general and specialty sessions, exhibits and fellowship occasions.

Principal speaker for the annual session is Dr. Richard E. Palmer of Alexandria, Va., president of the American Medical Association. He is scheduled to address the opening meeting of the House of Delegates on May 2, Dr. Gamble said.

OFFICIAL CALL

To all members of the Mississippi
State Medical Association:

The 109th Annual Session of the Mississippi State Medical Association is called to meet at Biloxi, Mississippi, on Monday, May 2, 1977, pursuant to Article V of the Constitution. The House of Delegates will be convened at 9 o'clock in the morning at the Sheraton-Biloxi on May 2.

The Scientific Assembly consisting of the 12 general sessions, will meet during May 1-4, 1977.

No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

LYNE S. GAMBLE

PRESIDENT

J. ELMER NIX

SECRETARY-TREASURER

The MSMA Auxiliary will conduct its 54th Annual Session concurrently during May 1-4, also headquartering at the Sheraton-Biloxi, according to Mrs. W. A. Brown, Jr., of Mathiston, state president. Mrs. William Hilbun of Meridian will be inaugurated 1977-78 president of the auxiliary at the meeting. General chairmen are Mrs. Edward Pennington of Ackerman, convention; Mrs. James Cooper of Tupelo, registration; Mrs. Tom Glasgow and Mrs. Bernard Hunt of Grenada, luncheon.

Medical alumni occasions are set for Monday evening and Ole Miss, Tulane and Tennessee have scheduled events. The annual association fellowship party will feature cocktails and hors d'oeuvres leaving convention-goers on their own for dinner at one of the Coast's many excellent restaurants. Party tickets will be \$6.00 per person and festivities are set for the Gulf Rooms at 6:00 p.m. on Tuesday, May 3. Tickets will be on sale at MSMA registration.

Room reservations at the Sheraton-Biloxi are being made through the MSMA office in Jackson; contact Barbara Shelton for assistance in this regard.

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LYNE S. GAMBLE
Greenville



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LIVING PAST PRESIDENTS

LAMAR ARRINGTON, Meridian	1952-53
S. LAMAR BAILEY, Kosciusko	1955-56
HOWARD A. NELSON, Greenwood	1957-58
GUY T. VISE, Meridian	1958-59
STANLEY A. HILL, Corinth	1959-60
G. SWINK HICKS, Natchez	1960-61
LAWRENCE W. LONG, Jackson	1961-62
C. P. CRENSHAW, Collins	1962-63
OMAR SIMMONS, Newton	1964-65
EVERETT CRAWFORD, Tylertown	1965-66
JAMES T. THOMPSON, Moss Point	1966-67
TEMPLE AINSWORTH, Jackson	1967-68
JOSEPH B. ROGERS, Biloxi	1968-69
JAMES L. ROYALS, Jackson	1969-70
PAUL B. BRUMBY, Lexington	1970-71
CHARLES R. JENKINS, Laurel	1972-73
ARTHUR A. DERRICK, JR., Durant	1973-74
J. T. DAVIS, Corinth	1974-75
JACK A. ATKINSON, Brookhaven	1975-76

ACTIVITIES CALENDAR

REGISTRATION

General Registration for the Scientific Assembly and House of Delegates will be located at the second level (Mezzanine) in the Sheraton-Biloxi. No person may be admitted to any activity of the annual session without first registering. **There will be a registration fee of \$25.00 for nonmember physicians except interns and residents.** Hours of registration will be 2:00 to 4:00 p.m., Sunday, May 1; 8:00 a.m. to 5:00 p.m., Monday, Tuesday, and Wednesday, May 2, 3 and 4; and 8:00 to 9:00 a.m., Thursday, May 5.

SUNDAY, MAY 1, 1977

12:00 noon Mississippi Psychiatric Association Luncheon and Business Meeting, Gulf Room B
12:00 noon Mississippi Association of Pathologists Luncheon, Boston Room
1:00 p.m. Mississippi Association of Pathologists Business Meeting, Biloxi Room

- 1:00 p.m. Genitourinary Seminar, Jackson Room
- 1:30 p.m. MSMA Scientific Meeting—Section on Psychiatry, Gulf Room A
- 2:00 p.m. MSMA Registration, Second Level Lobby
- 2:00 p.m. Auxiliary Hospitality Area, First Floor Lobby
- 2:00 p.m. MSMA Scientific Meeting—Section on Pathology, Biloxi Room
- 3:00 p.m. MSMA Scientific Meeting—Section on Anesthesiology, Gulf Room C
- 5:00 p.m. President's Reception, Top of the Sheraton (sponsored by Blue Cross-Blue Shield of Mississippi)
- 6:00 p.m. Mississippi Society of Anesthesiologists Dinner, Gulf Room D

MONDAY, MAY 2, 1977

- 7:00 a.m. MSMA Reference Committee Breakfast, Gulf Room D
- 9:00 a.m. MSMA House of Delegates, Top of the Sheraton
- 9:30 a.m. Auxiliary Finance Committee Meeting, Gulf Room B
- 10:30 a.m. Mississippi Orthopaedic Society Meeting, Gulf Room C
- 12:00 noon Mississippi Urological Society Luncheon, Gulf Room A
- 12:00 noon Mississippi Orthopaedic Society Luncheon, Gulf Room D
- 1:00 p.m. Mississippi Foundation for Medical Care Annual Meeting, Top of the Sheraton
- 2:30 p.m. MSMA Reference Committee on Reports of Trustees, Councils and Officers Meeting, Gulf Room B
- 3:00 p.m. Auxiliary Preconvention Board Meeting, Gulf Room D
- 3:30 p.m. MSMA Reference Committee Meeting—Council on Constitution and By-Laws, North Grand Ballroom
- 4:00 p.m. Ole Miss Medical Alumni Business Meeting, Jackson Room
- 6:00 p.m. University of Tennessee Medical Alumni Reception, Gulf Room C
- 6:30 p.m. Tulane University Medical Alumni Reception, Gulf Room A
- 7:00 p.m. Ole Miss Medical Alumni Seafood Jam-boree and Dance, Top of the Sheraton

TUESDAY, MAY 3, 1977

- 7:00 a.m. Mississippi Dermatological Society

APRIL 1977

Breakfast and Business Meeting, Empire Room

- 7:30 a.m. American College of Surgeons, Mississippi Chapter, Officers Breakfast, Biloxi Room
- 7:30 a.m. Breakfast Meeting of MSMA Board, Officers, and Component Society Presidents and Secretaries, Gulf Room A
- 9:00 a.m. MSMA Scientific Meeting—Section on Dermatology, Boston Room
- 9:00 a.m. MSMA Scientific Meeting—Section on Medicine, Gulf Room B
- 9:00 a.m. American College of Surgeons, Mississippi Chapter, Scientific Session, North Grand Ballroom
- 9:00 a.m. Auxiliary General Session, Gulf Room D
- 12:00 noon Mississippi Society of Internal Medicine Luncheon, Gulf Room C
- 12:15 p.m. American College of Surgeons, Mississippi Chapter, Luncheon, Gulf Room A
- 12:30 p.m. Mississippi Dermatological Society Luncheon Meeting, Biloxi Room
- 1:00 p.m. Auxiliary Luncheon, Top of the Sheraton
- 1:00 p.m. Academy of Facial Plastic and Reconstructive Surgery Video Cassette Showings on Soft Tissue Surgery, Boston Room
- 1:00 p.m. MSMA Scientific Meeting—Section on Radiology, Gulf Room D
- 1:30 p.m. MSMA Scientific Meeting—Section on Pediatrics, Gulf Room B
- 1:30 p.m. MSMA Scientific Meeting—Section on Surgery, North Grand Ballroom
- 1:30 p.m. Gastroenterology Organizational Meeting, Jackson Room
- 3:30 p.m. Auxiliary Postconvention Board Meeting, Jackson Room
- 5:00 p.m. Mississippi Radiological Society Cocktail Party, Gulf Room C
- 6:00 p.m. MSMA Annual Fellowship Party, Gulf Rooms A and B

WEDNESDAY, MAY 4, 1977

- 7:30 a.m. Academy of Facial Plastic and Reconstructive Surgery Breakfast and Scientific Program, Gulf Room C
- 7:30 p.m. MSMA Past Presidents' Breakfast, Boston Room
- 9:00 a.m. MSMA Scientific Meeting—Section on

Family Practice, North Grand Ballroom

- 9:00 a.m. MSMA Scientific Meeting—Section on EENT, Gulf Room B
- 9:00 a.m. Auxiliary Past Presidents' Breakfast, Jackson Room
- 9:00 a.m. Educational Advisory Committee of Mississippi Ob-Gyn Society Meeting, Board Room, 1st Floor
- 10:00 a.m. AMA-ERF Art Exhibit, Biloxi Room
- 11:00 a.m. MSMA Nominating Committee Meeting, Gulf Room D
- 11:30 a.m. Mississippi Ob-Gyn Society Luncheon, Gulf Room C
- 12:00 noon Mississippi EENT Association Luncheon, Gulf Room A
- 12:00 noon MSMA Fifty Year Club Luncheon, Boston Room
- 12:00 noon Mississippi Academy of Family Physicians Luncheon, Top of the Sheraton
- 1:30 p.m. Academy of Facial Plastic and Reconstructive Surgery Video Cassette Showings on Soft Tissue Surgery, Boston Room
- 1:30 p.m. MSMA Scientific Meeting—Section on Preventive Medicine, Gulf Room D
- 1:30 p.m. MSMA Scientific Meeting—Section on Ob-Gyn, Gulf Room B
- 3:00 p.m. Practical Tonometry Course, Gulf Room C
- 6:30 p.m. Flying Physicians Association Dinner, Jackson Room

THURSDAY, MAY 5, 1977

- 9:00 a.m. MSMA House of Delegates, Top of the Sheraton

EXECUTIVE BUSINESS



DR. TAYLOR

C. D. Taylor, Jr.
Pass Christian
Speaker



DR. TRIPLETT

R. Faser Triplett
Jackson
Vice Speaker

HOUSE OF DELEGATES

May 2, 1977, 9:00 a.m.
Sheraton-Biloxi

MEETINGS OF THE HOUSE OF DELEGATES

The opening meeting of the House will be called to order by the President, and the Speakers will announce the order of business. An open meeting on May 2, to which all MSMA members and Auxiliary members are invited will feature addresses by Dr. Lyne S. Gamble, the president, and Dr. Richard E. Palmer, president of the American Medical Association. The adjourned meeting of the House will convene at 9:00 a.m. on May 5.

REFERENCE COMMITTEES

Reports of Officers, Trustees, and Councils, May 2, 2:00 p.m., or immediately following MSMC Meeting, Top of the Sheraton

Constitution and By-Laws, May 2, 3:30 p.m., North Grand Ballroom

Nominating Committee, May 4, 11:00 a.m., Gulf Room D

THE SCIENTIFIC ASSEMBLY

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SCIENTIFIC AND TECHNICAL EXHIBITS

Grand Ballroom, Sheraton-Biloxi

THE SCIENTIFIC EXHIBIT

Physicians, foundations, organizations and major medical institutions will present the Scientific Exhibit. Physician-members of the Mississippi State Medical Association are eligible for the Aesculapius Award given for excellence of presentation, quality of content, and originality. Others may not participate in this competition, but they are eligible for the association's Scientific Achievement Award, a sculptured bronze medallion, in recognition of the best presentation by a nonmember. The Scientific Exhibit is located in the Grand Ballroom.

EXHIBITS AND AUTHORS

"Acute Supraglottic Laryngeal Edema: Silent Death"

Robert R. Gatling, V.A. Center, Jackson

"United Ostomy Association"

United Ostomy Association—Gulf Coast Chapter

"Cardiac Valve Replacement"

Martin H. McMullan and Thomas L. Kilgore,
Mississippi Baptist Medical Center, Jackson

"Adolescent Care Unit"

C. Mims Edwards, Brandon

"Blood Component Therapy"

Francis S. Morrison, Mississippi Regional Blood
Center, Jackson

"Cancer Education Service—Dial Access Program"
Southern Medical Association

"Endoscopic Approach to Jaundice" and "Endoscopic G.I. Tract Polypectomy—An Alternative to Surgery"

Jack B. Campbell, Edward M. Lowicki, and
Charles E. Farmer, Jackson

"Kidney Transplant Program for Mississippi"
George V. Smith, Department of Surgery, University of Mississippi Medical Center, Jackson

"Acquired Heart Disease—Diagnostic Methods and Surgical Therapy"

James L. Crosthwait, Quinton H. Dickerson,
James C. Hays, Jeff F. Hollingsworth, W. Arthur Jones, George K. McMullan, W. H. Rosenblatt,
Henry B. Tyler, Mississippi Heart Institute, St.

Dominic-Jackson Memorial Hospital, Jackson
"Mississippi Lions Eye Bank"

Kirby Miller, Executive Administrator, MLEB,
and Del Caldwell, Medical Advisor, MLEB;
Lions Sight Foundation of Mississippi, Inc.

"Mississippi Head and Neck Cancer Control Network"

Michael E. Jabaley, University of Mississippi
Medical Center, Jackson

"One Hundred Years of Public Health"

Mississippi State Board of Health

"Ventricular Aneurysm"

John L. Ochsner, Noel L. Mills, Tommy Fudge,
and David Glassford, Ochsner Clinic, New Orleans

"Prevent Blindness"

Mississippi Society for the Prevention of Blindness

THE TECHNICAL EXHIBIT

The Mississippi State Medical Association presents with pride the 1977 Technical Exhibit. Established firms engaged in the manufacture and distribution of pharmaceuticals, supplies, or equipment, and in providing varied services, will present the exhibits. Visit each exhibit often and discuss products and services with the Professional Service Representatives. Only registered members and guests are admitted. The technical Exhibit is located in the Grand Ballroom.

EXHIBITORS

Ames Co., Div. of Miles Labs, Elkhart, IN
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Healthco/Mississippi Surgical, Jackson, MS

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 Medical Business Services, Inc., Jackson, MS
 Medical and Corporate Financial, Inc., Jackson, MS
 Meyer Laboratories, Inc., Ft. Lauderdale, FL
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REGISTRATION FOR EXHIBIT PRIZES

Visit the Technical Exhibits often and qualify for the drawing of attractive prizes. Obtain necessary initials as you visit each booth. Drawing for exhibit attendance prizes will be held at MSMA registration on Wednesday at 5:00 p.m.

SCIENTIFIC GRANTS

A. H. Robins Company, Richmond, VA
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 Geigy Pharmaceuticals, Ardsley, NY
 Winthrop Laboratories, New York, NY

Special Sponsorship—President's Reception—Blue Cross-Blue Shield of Mississippi

Program is acceptable for 14 prescribed hours by the American Academy of Family Physicians and 14 hours Category I credit, AMA physicians recognition awards.

SCIENTIFIC PROGRAM— Section on Psychiatry

Sunday, May 1, 1977
 Gulf Room A
 Beginning at 1:30 p.m.

Barbara Goff, Jackson
 Chairman
 Glen Anderson, Brandon
 Secretary



DR. GOFF

SHORT COURSE IN:

TREATMENT OF NEUROTIC ANXIETY AND DEPRESSIVE DISORDERS

James L. Claghorn, clinical associate professor in psychiatry, University of Texas Medical School, Houston, and associate professor in psychiatry, Baylor College of Medicine

Supported by a grant from Pfizer, Inc.

SCIENTIFIC PROGRAM— Section on Pathology

Sunday, May 1, 1977
 Biloxi Room
 Beginning at 2:00 p.m.

Ben F. Martin, III, Columbus
 Chairman
 William B. Wilson, Jackson
 Secretary



DR. MARTIN

SHORT COURSES IN:

CHARACTERIZATION AND CLASSIFICATION OF MALIGNANT LYMPHOMAS BY IMMUNOLOGIC TECHNIQUES

Joel Brunson and Julius M. Cruse, Department of Pathology, University Medical Center, Jackson

CURRENT USE OF THE ELECTRON MICROSCOPE IN DIAGNOSTIC BIOPSIES AND TUMOR DIAGNOSIS

Virginia Lockard, Department of Pathology, University Medical Center, Jackson

SCIENTIFIC PROGRAM—

Section on Anesthesiology

Sunday, May 1, 1977

Gulf Room C

Beginning at 3:00 p.m.

Marion P. Parker, Jackson

Chairman

Katherine Aldridge,

Hattiesburg

Secretary



DR. PARKER

SHORT COURSE IN:

INTRAOPERATIVE USE OF FLUIDS AND ELECTROLYTES

—AN UPDATE FOR ANESTHESIOLOGISTS

A. H. Giesecke, professor and vice chairman, Department of Anesthesiology, University of Texas Southwestern Medical School, Dallas

SCIENTIFIC PROGRAM—

Section on Dermatology

Tuesday, May 3, 1977

Boston Room

Beginning at 9:00 a.m.

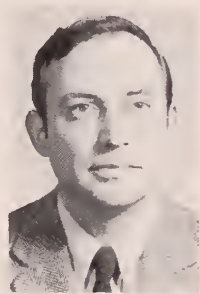
Louis J. Wise, Jackson

Chairman

John A. Marascalco,

Greenville

Secretary



DR. WISE

SHORT COURSES IN:

SPECIAL TREATMENT SITUATIONS IN DERMATOLOGY

Peyton E. Weary, professor and chairman, Department of Dermatology, University of Virginia at Charlottesville

PANEL DISCUSSION ON DERMATOLOGICAL PROBLEMS

Part I: Directed by Ronald R. Lubritz, Hattiesburg

Part II: Directed by James M. McQueen, Jackson

Supported in part by a grant from Westwood Pharmaceuticals.

SCIENTIFIC PROGRAM—

Section on Medicine

Tuesday, May 3, 1977

Gulf Room B

Beginning at 9:00 a.m.

Quinton H. Dickerson, Jr.,

Jackson

Chairman

Don Q. Mitchell, Jackson

Secretary



DR. DICKERSON

SHORT COURSES IN:

MEDICAL VS. SURGICAL JAUNDICE—NEW

APPROACHES TO OLD PROBLEMS

Walter T. Boone, Jackson

NEWER LABORATORY AIDS IN THE DIAGNOSIS AND

MANAGEMENT OF RHEUMATIC SYNDROMES

James B. Pennebaker, Jackson

PULMONARY THROMBOEMBOLIC DISEASE

George McMullan, Jackson

RATIONAL USE OF THE MICROBIOLOGY LABORATORY

Charles Sanders, chief, Division of Infectious Diseases, LSU School of Medicine, New Orleans

Supported by grants from the Merck Sharp and Dohme Postgraduate Program and The Upjohn Company.

SCIENTIFIC PROGRAM—

Section on Radiology

Tuesday, May 3, 1977

Gulf Room D

Beginning at 1:00 p.m.

Charles A. Ray, III, Meridian

Chairman

Bernard Blumenthal, Jackson

Secretary



DR. RAY

SHORT COURSE IN:

WHOLE BODY COMPUTED AXIAL TOMOGRAPHY—

CURRENT STATE OF THE ART

William V. Glenn, director of C.T., Long Beach Memorial Hospital, Long Beach, CA

SCIENTIFIC PROGRAM—

Section on Surgery

Tuesday, May 3, 1977

North Ballroom

Beginning at 1:30 p.m.

Henry B. Tyler, Jackson

Chairman

Jerry R. Adkins, Biloxi

Secretary



DR. TYLER

SECTION ON SURGERY / Continued

SHORT COURSES IN:

POSTOPERATIVE PULMONARY COMPLICATIONS AND THEIR PREVENTIONS

Robert Bartlett, associate professor of surgery,
University of California, Irvine, CA

ISLET CELL TUMORS IN THE GASTROINTESTINAL TRACT

Robert Zollinger, professor and chairman emeritus,
Department of Surgery, Ohio State University Col-
lege of Medicine, Columbus, OH

MEDICAL LEGAL ASPECTS OF BREAST DISEASE

James P. Spell, Jackson

UNDESCENDED TESTES IN CHILDREN

James E. Keeton, Jackson

SCIENTIFIC PROGRAM—

Section on Pediatrics

Tuesday, May 3, 1977

Gulf Room B

Beginning at 1:30 p.m.

Robert L. Abney, III, Jackson
Chairman

Robert H. Thompson, Jr.,
Jackson
Secretary



DR. ABNEY

SHORT COURSES IN:

GENETIC PRINCIPLES FOR THE CLINICIAN

Lt. Col. Barry H. Thompson, MC, USAF, as-
sistant chairman, Department of Pediatrics, and
director, Cytogenetic Laboratory, USAF Medical
Center, Keesler, Biloxi

COMMON GENETIC PROBLEMS/THERAPY

Lt. Col. Thompson

GENETIC COUNSELING TECHNIQUES

Lt. Col. Thompson

CHILDHOOD SCOLIOSIS

Buford Yerger and Ward T. McCraney, Jackson

Supported by a grant from Ross Laboratories.

SCIENTIFIC PROGRAM— Section on EENT

Wednesday, May 4, 1977

Gulf Room B

Beginning at 9:00 a.m.

J. George Smith, Jackson
Chairman

W. J. Burnett, Oxford
Secretary



DR. SMITH

SHORT COURSES IN:

BLEPHAROPLASTY—TECHNIQUES AND HOW TO AVOID COMPLICATIONS and

DIAGNOSIS AND MANAGEMENT OF EPIPHORA

Howard L. Beale, chief, ophthalmic plastic surgery
service, University of Tennessee, Memphis

"LASER SURGERY OF THE LARYNX"

Ray Lusteau, M.D., Division of Otolaryngology,
LSU School of Medicine, New Orleans, La.

WEDGE RESECTION OF THE LID AND SURGICAL MANAGEMENT OF THE RETRACTORS OF THE LID Dr. Beale

"OTHER USES OF THE LASER IN ENT"

Dr. Lusteau

Supported by grants from Dista Laboratories, Scher-
ing, Pfizer Labs, UAD, and Hoffman-LaRoche.

SCIENTIFIC PROGRAM—

Section on Family Practice

Wednesday, May 4, 1977

North Ballroom

Beginning at 9:00 a.m.

John M. Estess, Hollandale
Chairman

Hardy B. Woodbridge, Jackson
Secretary



DR. ESTESS

SHORT COURSES IN:

BLOOD TRANSFUSION 1977

Francis S. Morrison, professor of medicine, Uni-
versity Medical Center, Jackson

INSECT BITES AND STINGS INCLUDING EMERGENCY TREATMENT AND HYPOSENSITIZATION

Claude A. Frazier, Asheville, NC

THE FAMILY PRACTITIONER AND PEDIATRIC ORTHOPEDICS

Douglas C. Brown, Laurel

DRUG USE AND ABUSE

A. G. Anderson, Jr., Walterine H. Bell, Charles E.
Bell, and William A. Jaquith, Jackson

SCIENTIFIC PROGRAM—
Section on Ob-Gyn

Wednesday, May 4, 1977
Gulf Room B
Beginning at 1:30 p.m.

Calvin Hull, Jackson
Chairman

Wadie Abraham, Meridian
Secretary



DR. HULL

Supported by Mead Johnson Laboratories, Ross Laboratories, Geigy Pharmaceuticals, and the Mississippi Association of Public Health Physicians.

SHORT COURSES IN:

**POSTOPERATIVE INFECTIONS IN OBSTETRICS
AND GYNECOLOGY**

Ronald S. Gibbs, assistant professor, Department of Obstetrics and Gynecology, University of Texas Health Science Center, San Antonio

**INFECTIONS RELATED TO THE TREATMENT OF
GYNECOLOGIC ONCOLOGY PATIENTS:**

DIAGNOSIS AND MANAGEMENT

Robert W. Swan, assistant professor, Department of Obstetrics and Gynecology, University Medical Center, Jackson

**PROPHYLACTIC ANTIBIOTICS IN OBSTETRICS
AND GYNECOLOGY**

Dr. Gibbs

SCIENTIFIC PROGRAM—
Section on Preventive Medicine

Wednesday, May 4, 1977
Gulf Room D
Beginning at 1:30 p.m.

Alfio Rausa, Greenwood
Chairman

W. E. Riecken, Jackson
Secretary



DR. RAUSA

SHORT COURSES IN:

**IMPROVED PREGNANCY OUTCOME IN THE ABSENCE
OF AN OBSTETRICIAN—A CASE REPORT**

J. Edward Hill, Hollandale

**THE COMMUNITY MENTAL HEALTH CENTER, AN
ALLY TO BOTH CURATIVE AND
PREVENTIVE MEDICINE**

Kinloch Gill, Jr., Executive Director, Region VI Mental Health-Mental Retardation Center, Greenwood

OUT OF STATE ESSAYISTS



ROBERT BARTLETT,
Irvine, CA



HOWARD LEO BEALE,
Memphis



CLAUDE A. FRAZIER,
Asheville, NC



RONALD S. GIBBS,
San Antonio



A. H. GIESECKE,
Dallas



CHARLES SANDERS,
New Orleans



BARRY THOMPSON,
USAF MC



PEYTON E. WEARY,
Charlottesville, VA



ROBERT ZOLLINGER,
Columbus, OH

SUNDAY, MAY 1, 1977

MISSISSIPPI ASSOCIATION OF PATHOLOGISTS

The Mississippi Association of Pathologists will meet for a luncheon, followed by a business meeting, on Sunday, May 1, at 12:00 noon. The luncheon will be in the Boston Room and the business meeting and scientific section will convene in the Biloxi Room. Officers are Ben F. Martin of Columbus, president; Roland F. Samson of Jackson, president-elect; William B. Wilson of Jackson, secretary; and Allen M. Read of Natchez, treasurer.

MISSISSIPPI PSYCHIATRIC ASSOCIATION

The Mississippi Psychiatric Association will hold a luncheon and business meeting on Sunday, May 1, at 12:00 noon in Gulf Room B. President is Barbara Goff of Jackson; vice president is J. E. Ruff of Jackson; secretary is Glen Anderson of Brandon; and treasurer is Mary Hogan of Whitfield.

GENITOURINARY SEMINAR

The Mississippi Urological Society will sponsor a genitourinary seminar on Sunday afternoon, May 1, from 1:00 to 4:00 p.m. in the Jackson Room of the Sheraton-Biloxi. Members of the society will present papers oriented toward the family practitioner. There will be a \$5.00 registration fee and the meeting will be open to all.

MISSISSIPPI SOCIETY OF ANESTHESIOLOGISTS

The Mississippi Society of Anesthesiologists will host a dinner following the section program on Sunday, May 1, at 6:00 p.m. in Gulf Room D. Marion P. Parker of Jackson is president and David I. Carlson of Jackson is secretary-treasurer.

MONDAY, MAY 2, 1977

REFERENCE COMMITTEE BREAKFAST

Members of all reference committees of the House of Delegates will meet for breakfast on Monday morning, May 2, in Gulf Room D at 7:00 a.m. Hosts are C. D. Taylor, Jr., of Pass Christian, speaker, and R. Faser Triplett of Jackson, vice speaker. At this important meeting, committee members will be instructed in their duties and conduct of hearings to be held later in the day.

MISSISSIPPI ORTHOPAEDIC SOCIETY

The Mississippi Orthopaedic Society will sponsor a scientific meeting from 10:30 a.m. until 3:00 p.m. on Monday, May 2, in Gulf Room C. Members will break for a luncheon at 12:00 noon in Gulf Room C. Officers are Cleve E. Johnson of Laurel, president; J. Elmer Nix of Jackson, president-elect; Hugh P. Brown of Jackson, secretary; and Wayne T. Lamar of Oxford, vice president.

MISSISSIPPI UROLOGICAL SOCIETY

The Mississippi Urological Society will hold a business meeting and luncheon on Monday, May 2, at 12:00 noon in Gulf Room A. Gerald Wessler of Gulfport is president and William C. Gates of Columbus is president-elect and secretary-treasurer.

MISSISSIPPI FOUNDATION FOR MEDICAL CARE

The Mississippi Foundation for Medical Care will hold its annual meeting on Monday afternoon, May 2, beginning at 1:00 p.m. on the Top of the Sheraton. All members are urged to attend.

TULANE MEDICAL ALUMNI

Medical graduates of Tulane University will be feted at a reception on Monday evening, May 2, in Gulf Room A, at 6:30 p.m. Ms. Wendy B. Kornegay, Medical Alumni Coordinator at Tulane, is aiding in arrangements.

THE UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE ALUMNI RECEPTION

Medical alumni of the University of Tennessee will enjoy a reception on Monday evening, May 2, in Gulf Room C from 6:00 to 7:30 p.m. John Sheridan, Director of Alumni Affairs at UT, is in charge of arrangements.

OLE MISS MEDICAL ALUMNI

University of Mississippi medical alumni, families and guests will meet on Monday, May 2, at the Sheraton-Biloxi. Alumni registration will be located adjacent to MSMA general registration in the second floor lobby and will be open at 8:00 a.m. where tickets for the evening party will be available. A general business meeting will be conducted at 4:00 p.m. on Monday in the Jackson Room. The cocktail party and seafood jamboree will begin at 7:00 p.m. on the Top of the

Shcraton. Dr. Berlyn Edwards of Biloxi is program planning committee chairman. Committee members are Leonard D. Ball, Thomas C. Garrott and Thurman T. Justice, all from the Coast. Charles Farris, Jr., of New Orleans, medical alumni president, will preside. President-elect is R. Faser Triplett of Jackson.

TUESDAY, MAY 3, 1977

MSMA OFFICERS BREAKFAST

On Tuesday, May 3, at 7:30 a.m. in Gulf Room A, the MSMA Board of Trustees, officers and component society presidents and secretaries will hold a breakfast meeting to discuss MSMA organization and activities.

AMERICAN COLLEGE OF SURGEONS, MISSISSIPPI CHAPTER

The American College of Surgeons, Mississippi chapter, will sponsor a scientific program on Tuesday morning, May 3, beginning at 9:00 a.m., in the North Grand Ballroom. The program is:

The Status and Clinical Usage for the Artificial Lung

Robert Bartlett, associate professor of surgery, University of California at Irvine

Some Observations on Gastric Surgery

Robert M. Zollinger, chairman, department of surgery, Ohio State University, Columbus

Case Presentations

1. Frank Briggs, Jackson

2. Jefferson Hollingsworth, Jackson

First Rib Fracture: Is Arteriography Indicated?

Joseph G. Stribling, resident in surgery, University Medical Center, Jackson

A business meeting will follow from 11:30 a.m. until 12:15 p.m. when fellows will adjourn for luncheon in Gulf Room A. Officers of the college are Thomas Barnes of Greenville, president; John R. Lovelace of Batesville, president-elect; and W. B. Hopson, Jr., of Vicksburg, secretary-treasurer. ACS officers will meet for breakfast at 7:30 a.m. on May 3, in the Biloxi Room.

MISSISSIPPI SOCIETY OF INTERNAL MEDICINE

The Mississippi Society of Internal Medicine will have a luncheon on Tuesday, May 3, at 12:00 noon in Gulf Room C. A. Robert Dill of Columbus is president; James C. Hays of Jackson is secretary and president-elect. Bruce E. Atkinson of Amory will take office this year as secretary-treasurer.

MISSISSIPPI DERMATOLOGICAL SOCIETY

The Mississippi Dermatological Society will host a breakfast and business meeting at 7:00 a.m. in the Empire Room and a luncheon at 12:30 p.m. on Tuesday, May 3, in the Biloxi Room. A business meeting will follow and guest speaker will be Tom Jansen. Officers are Louis J. Wise of Jackson, president; Ronald R. Lubritz of Hattiesburg, president-elect; and John A. Marascalco, secretary-treasurer.

AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY AUDIOVISUAL LIBRARY TAPES

The Mississippi chapter of the American Academy of Facial Plastic and Reconstructive Surgery will sponsor video cassette showings of soft tissue surgery on Tuesday from 1:00-5:00 p.m. and on Wednesday from 1:30-5:00 p.m. in the Boston Room. All physicians who do any aspect of soft tissue surgery of the head and neck are invited to participate.

MISSISSIPPI STATE RADIOLOGICAL SOCIETY

The Mississippi State Radiological Society will host a cocktail party following the section meeting at 5:00 p.m. on Tuesday, May 3, in Gulf Room C. Officers are Clifton L. Hester, Jr. of Jackson, president; Charles A. Ray of Meridian, president-elect; and John Y. Gibson of Jackson, secretary.

ASSOCIATION FELLOWSHIP PARTY

Members of the Mississippi State Medical Association, their families and guests will enjoy a fellowship cocktail party on Tuesday evening, May 3, in Gulf Rooms A and B, beginning at 6:00 p.m. Tickets are available at the MSMA registration desk.

WEDNESDAY, MAY 4, 1977

ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

The American Academy of Facial Plastic and Reconstructive Surgery will host a breakfast on Wednesday, May 4, at 7:30 a.m. in Gulf Room C. Business and scientific sessions will follow. Officers are president, Larry H. Day, of Hattiesburg; vice president, Kenneth N. Reed of Jackson; and secretary, J. George Smith of Jackson.

MSMA PAST PRESIDENTS' BREAKFAST

Past presidents of the Mississippi State Medical Association will enjoy a fraternal breakfast on Wednesday morning, May 4, at 7:30 a.m. in the Boston Room. Dr. Jack A. Atkinson of Brookhaven is host.

MISSISSIPPI OB-GYN SOCIETY

The Mississippi Ob-Gyn Society will conduct a luncheon meeting on Wednesday, May 4, at 11:30 a.m. in Gulf Room C. Society officers are Richard Hollis of Amory, president; Kenneth Pittman of Jackson, president-elect; and Lewis D. Lipscomb of Jackson, secretary-treasurer.

FIFTY YEAR CLUB

The Board of Trustees, sponsors of the association's Fifty Year Club, will honor the half-century plus members at a special luncheon on Wednesday, May 4, in the Boston Room. Robert S. Caldwell of Tupelo, chairman of the Board of Trustees, will preside.

MISSISSIPPI ACADEMY OF FAMILY PHYSICIANS

The Mississippi Academy of Family Physicians will sponsor a luncheon meeting at 12:00 noon on Wednesday, May 4, in the Top of the Sheraton. Officers of the academy are president, Walter H. Rose of Indianola; vice president, John M. Estess of Hollandale; president-elect, Ralph Brock of McComb; and secretary, Edgar D. Johnson of Hattiesburg.

MISSISSIPPI EENT ASSOCIATION

The Mississippi EENT Association will hold a luncheon and business meeting on Wednesday, May 4, at 12:00 noon in Gulf Room A. Association officers are president, Larry H. Day of Hattiesburg; vice president, Leighton Pettis of Tupelo; and secretary-treasurer, Wilson Moak of Jackson.

SHORT COURSE IN TONOMETRY

The Mississippi EENT Association will sponsor a short course in tonometry for family physicians on Wednesday, May 4 at 3:00 p.m. in Gulf Room C. Samuel B. Johnson of Jackson is course instructor. Those taking the course are eligible for one hour of credit from the American Academy of Family Physicians.

FLYING PHYSICIANS ASSOCIATION, MISSISSIPPI CHAPTER

The Mississippi chapter of the Flying Physicians Association, Inc., will host a dinner and program on Wednesday, May 4, at 6:30 p.m. in the Jackson Room. All interested parties are invited to attend. John J. White of Jackson is president and H. Davis Dear of Jackson is secretary.

MSMA TENNIS TOURNAMENT

MSMA will sponsor a tennis tournament with men's and women's doubles on Wednesday afternoon, May 4. See the full page display on page 92 of this issue of the JOURNAL. Dr. Henry B. Tyler of Jackson is chairman.

MISSISSIPPI STATE MEDICAL ASSOCIATION AUXILIARY

54th Annual Session

The Sheraton-Biloxi

May 1-4, 1977



MRS. BROWN



MRS. HILBUN

OFFICERS

MRS. W. A. BROWN, JR.	MRS. WM. HILBUN, JR.
Mathiston	Meridian
President	President-elect

MRS. W. MONCURE DABNEY
Crystal Springs, Treasurer

Mrs. Edward Pennington Ackerman Convention Chairman	Mrs. James Cooper Tupelo Registration
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Mrs. Tom Glasgow Grenada Luncheon Co-Chairmen	Mrs. Bernard Hunt Grenada
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AUXILIARY

Sunday, May 1, 1977

2:00-6:00 p.m. Registration, Second Floor Lobby

2:00-6:00 p.m. Hospitality, Lobby Lower Level

Monday, May 2, 1977

9:00 a.m.-5:00 p.m. Registration, Second Floor Lobby

9:30 a.m. Finance Committee Meeting, Gulf Room B

3:00 p.m. Preconvention Board Meeting, Gulf Room D

4:30 p.m. Coffee honoring County Presidents and State Chairmen, Poolside. All members invited

Tuesday, May 3, 1977

9:00 a.m. Coffee, Gulf Room D

9:30 a.m. General Session, Gulf Room D

Invocation

Introductions

Greetings

Richard E. Palmer, M.D., President, AMA

Mrs. Norman H. Gardner, President, AMA Auxiliary

Lyne S. Gamble, M.D., President, MSMA

James O. Gilmore, M.D., President-elect, MSMA

Speaker—Dr. Palmer

Welcome

Response

Memorial

Speaker—Mrs. Gardner

Roll Call

Minutes

Reports

Appointment of Delegates to AMA Auxiliary Annual Meeting

Business

Election of Officers

Installation of Officers

Courtesy Resolutions

Adjournment

1:00 p.m. Crafts Luncheon, Top of the Sheraton

Invocation

Introductions

Guest Speaker—Mrs. Gardner

Presentation of Officers

Awards

Style Show

3:30 p.m. Postconvention Board Meeting, Jackson Room

Wednesday, May 4, 1977

9:00 a.m. Past Presidents' Breakfast, Jackson Room

10:00 a.m.-12:00 noon AMA-ERF Art Exhibit, Biloxi Room

AUXILIARY ANNUAL SESSION COMMITTEE CHAIRMEN

Sunday's Welcome Booth

Mrs. Doyle Smith
Jackson

Mrs. William Bowlus
Jackson

★ ★ ★

Art Exhibit—AMA-ERF
The Coast Auxiliaries

★ ★ ★

Poolside Coffee

Mrs. Dempsey Amacker
Natchez

Mrs. Donald Barraza
Natchez

★ ★ ★

Hospitality

Mrs. T. A. Baines
Jackson

Jones County Medical Auxiliary

★ ★ ★

Hostess

Mrs. Edward Hill
Hollandale

★ ★ ★

Publicity

Mrs. Lee Rogers
Tupelo



The President Speaking

The AMA and National Health Insurance

LYNE S. GAMBLE, M.D.
Greenville, Mississippi

THE ACTIONS OF THE House of Delegates of the AMA on national health insurance have spanned eight years. At the clinical meeting in 1968, the House adopted the principle of graduated income tax credits on insurance premiums and called for the AMA to draft and promote federal legislation to implement this principle. At the 1970 annual convention, the House approved Report V of the Board of Trustees which formally presented the "concept and design" of AMA's Mediredit bill and a draft of the Health Insurance Systems Act of 1970 was approved. This measure was introduced into the 91st Congress as HR 18567. Subsequently, NHI bills supported by the AMA were introduced in the 92nd, the 93rd, and the 94th congresses. These bills were founded on policies established by the House of Delegates.

At the recent clinical convention in Philadelphia, after long debate by a vote of 181 to 57, the House of Delegates approved the Comprehensive Health Care Insurance Act of 1977. This act was introduced into the Senate by Senator Clifford P. Henson (R-Wyo.), S218 and in the House by representatives Tim Lee Carter (R-Ky.), John M. Murphy (D-N.Y.), and John J. Duncan (R-Tenn.), HR 1818. Regardless of our individual sentiments relative to this action, I feel that it is incumbent upon us to be familiar with the provisions of this bill.

The basic concept of this proposal is full health care for all persons through private health insurance. Equally comprehensive benefits will be available to the poor and the indigent, through federal participation in the cost of insurance. A special program of supplemental insurance will provide like protection for the Medicare population.

Most persons will receive their health care protection under employer-employee insurance programs fully financed by premiums paid by employers and their employees. Employers will be required to offer the coverage and participation will be optional for the employee. Sixty-five per cent of the premium will be payable by the employer (who could, if individually agreed upon, pay more than sixty-five per cent).

Needs of the poor and the medically indigent will be met through a system of insurance premium subsidies providing either credits against income tax, or "certificates of entitlement" acceptable by carriers toward payment of premium. Such subsidies will be scaled according to income and will pay all of the premium for some and a part of the premium for others. The amount of the federal contribution will be based on individual or family income,

(Continued on page 107)

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVIII, NUMBER 4

APRIL 1977



EDITORIALS

Pollution and the Future

We are becoming increasingly conscious of our ecology. The news media remind us daily of pollution, threat of oil spills, chemical contaminants in

measured by income tax liability for the year preceding the year for which the purchase is made.

Health benefits under the program are comprehensive and afford the basic needs as well as catastrophic expenses that a family might encounter. The benefits cover full hospital care, full physician care (wherever provided, both in and out of the hospital), home health services, emergency care, lab and x-ray services, extended care services, etc. The range of benefits embrace preventive diagnostic and therapeutic services.

To keep costs down, and as a curb against overutilization, individuals will be subject to a payment of 20 per cent (called "co-insurance") of health benefits derived. However, the total co-insurance which a family will have to pay in any year will be limited according to its income. The poor will pay no co-insurance. Others will pay a maximum in any year of 10 per cent of income reduced by a "co-insurance deduction." In no case could the annual co-insurance limit be more than \$1,500.00 for an individual or \$2,000.00 for a family. The limitation on co-insurance triggers the catastrophic expense protection. Health services are free of co-insurance when this limit is reached.

Insurance will be available to all persons, regardless of prior medical history and on a guaranteed renewable basis.

The 1977 bill would allow everyone to choose his own physician, dentist, and health insurance plan. Preventive care benefits would include well baby care, physical examination, immunizations, and inoculations, outpatient psychiatric care, and x-ray and laboratory work. ★★★

our drinking water, the dangers, imagined or real, of nuclear generation of energy. Despite our ability to land men on the moon and manufacture calculators that do startling computations at a very nominal price, we appear unable to deal with our social problems.

In the final analysis, people are the cause of pollution. And people are the users of energy. While our rate of population increase is leveling off, we are still not approaching zero growth. It is apparent that there is a limit to our energy source as we know it today. Our use of petroleum is higher now than when we had the scare two years ago. The end of petroleum is in sight and our coal resources are estimated to last only 300 years.

In addition, man's longevity has increased greatly. While seeking a solution to our dilemma, isn't it time we backed off by limiting our population rather than further "compounding the felony."

Who better than the medical profession can lead us in this direction? There are many people who desire sterilization but can't afford it which results in more unwanted children. Our federal social programs support patients on artificial kidney machines at great expense to the taxpayers. Should not we offer sterilization at society's expense to all who desire it but cannot afford it?

Our grandchildren may well not have food and fibre if the trend continues.

W. MONCURE DABNEY, M.D.

Editor

Crystal Springs, MS

Medico-Legal Brief

EXPERT TESTIMONY NECESSARY TO PROVE MALPRACTICE

Expert testimony was necessary to prove that a patient's skin graft had healed improperly at the

time he left the hospital, a District of Columbia appellate court ruled.

The patient, a five-year-old boy, severely scalded his left hand. Seventeen days after his admission, a skin graft was performed on his hand with a segment of skin removed from his thigh. He continued to receive treatment and therapy until his discharge from the hospital. An appointment was made with the physician for a week later, and his mother was instructed to bring him back to the hospital twice a week for physical therapy. The mother did not take the child back to the hospital for therapy, nor did she return to the physician, despite repeated telephone calls from his office.

He received no further treatment until he was taken to a children's hospital for treatment of a rash eight months later. Physicians there discovered that the skin between his fingers had grown together, making him unable to move his hand. They also discovered that keloids had formed on his thigh.

Claiming damages for injuries to her son, the mother filed a malpractice suit against the physician who treated her son and the hospital. The mother contended that expert testimony was not required because the doctrine of *res ipsa loquitur* applied. The trial court disagreed and directed a verdict for the hospital and physician on the ground that the mother had failed to provide any evidence of the standard of care applicable to the treatment challenged and had failed to show that the child's injury was caused by such treatment.

On appeal, the court agreed that expert testimony was not necessary in cases in which *res ipsa loquitur* applied. However, without expert testimony, the jury could not be permitted to infer negligence from the mere fact that the injury had occurred. Because of the complexities of treatment it was not common knowledge that deformity is caused only by negligent treatment.

The physician testified that he followed standard procedures in performing the skin graft. He also observed at the trial that the child was apparently a keloid-former and that he might have tried to prevent keloid formation with x-ray treatment had he known that fact. He also stated that there was no way to determine who will be a keloid-former.

Nothing in the physician's testimony provided a basis for *res ipsa loquitur*, the court said. The jury could only speculate on possible negligence by the physician and the hospital. The trial court's decision was affirmed.—*Harris v. Cafritz Memorial Hospital*, 364 A.2d 135 (D.C.Ct. of App., Sept. 20, 1976)



NEW MEMBERS

BROWN, DOUGLAS C., Laurel. Born Washington, DC, Dec. 29, 1942; M.D., University of Virginia School of Medicine, Charlottesville, VA, 1968; interned Tulane Charity Hospital, New Orleans, LA, one year; orthopaedic surgery residency, Ochsner Clinic, New Orleans, 1972-75; fellowship in pediatric orthopedics, Newington Children's Hospital, Newington, CT, 1975-76; elected by South Mississippi Medical Society.


DE BERARDINIS, MICHAEL C., Houston. Born Wichita, KS, Sept. 12, 1942; M.D., Louisiana State University School of Medicine, New Orleans, 1967; interned Confederate Memorial Hospital, Shreveport, LA, one year; urology residency, St. Joseph's Hospital, Houston, TX, 1968-69; urology residency, University of Texas, Houston, TX, 1971-74; elected by Northeast Mississippi Medical Society.

HOLBERT, ROBERT DOUGLAS, Jackson. Born San Francisco, CA, Aug. 28, 1940; M.D., Tulane University School of Medicine, New Orleans, LA, 1967; interned University of Texas, San Antonio, one year; internal medicine residency, Tulane, Sept. 1970-Sept. 1972; nephrology residency, Ochsner Hospital, New Orleans, LA, Sept. 1972-Sept. 1973; fellowship in nephrology, LSU, New Orleans, LA, Sept. 1973-Sept. 1974; elected by Central Medical Society.

HUTCHINSON, CLYDE M., Tupelo. Born Columbus, MS, Aug. 18, 1943; M.D., Tulane University School of Medicine, New Orleans, LA, 1969; interned University of Alabama, Birmingham, AL, one year; surgery residency, same, 1970-71; surgery residency, Ochsner Clinic, New Orleans, LA, 1971-74; elected by Northeast Mississippi Medical Society.

JORDAN, BILLY JOE, Grenada. Born Crossett, AR, Oct. 14, 1930; M.D., University of Arkansas School of Medicine, Little Rock, AR, 1960; interned Bethany Methodist Hospital, Kansas City, KS, one year; radiology residency, Baptist Medical Center, Little Rock, AR, 1961-64; elected by North Central Medical Society.

MAYO, JOHN M., Columbus. Born Sallisaw, OK, Mar. 28, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned Hillcrest Medical Center, Tulsa, OK, one year; elected by Prairie Medical Society.



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

- **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.
- **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.
- **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg/kg/day in rabbits and 10 mg/kg/day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children. Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy. See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG 

A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert[®]/25 
(meclizine HCl) 25 mg. Tablets
for vertigo*

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with

cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy. Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and

leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

MORRIS, CHARLES H., Jackson. Born Oct. 14, 1945; M.D., Louisiana State University, New Orleans, 1970; interned University of Arkansas, Little Rock, AR, one year; radiology residency, same, July 1971-Dec. 1972; radiology residency, Charity Hospital, New Orleans, LA, Jan. 1973-July 1974; elected by Central Medical Society.

SANDIFER, FRED M., III, Greenwood. Born Greenwood, MS, July 25, 1942; M.D., Tulane University School of Medicine, New Orleans, LA, 1968; interned Charity Hospital, New Orleans, one year; orthopedic surgery residency, V.A. Hospital, Memphis, TN, 1969-70; orthopedic surgery residency, Campbell Clinic, Memphis, TN, 1970-73; elected by Delta Medical Society

STUBBLEFIELD, EARL T., Jackson. Born Ft. McClellan, AL, April 29, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1970; internship and ob-gyn residency, same, 1970-74; elected by Central Medical Society.



DEATHS

BRAMLETT, JULIAN C., Oxford. Born Oxford, MS, Aug. 23, 1926; M.D., University of Pennsylvania School of Medicine, Philadelphia, Pa., 1955; interned Baptist Hospital, Memphis, TN, one year; surgery residency, John Gaston Hospital, Memphis, TN, July 1956-July 1960; died Feb. 16, 1977, age 50.



PERSONALS

EMIL and AMORNAT AFTANDILIAN have joined the staff at Senatobia Community Hospital. Dr. Emil Aftandilian has training in general surgery and Dr. Amornrat Aftandilian's specialty is internal medicine.

DUFF D. AUSTIN of Newton announces the closing of his practice of medicine.

WILLIAM BRADFORD of Pascagoula was guest instructor and co-director of a course in advanced life-saving measures for heart patients at UMC in Jackson.

THOMAS J. DEWEY, III, of Hattiesburg and WILLIAM L. HAND of Meridian were inducted as Fellows of the American Academy of Orthopaedic Surgery at the group's annual meeting in Las Vegas.

NICHOLAS DISANTI of Pascagoula served as King of Joy at the 40th annual coronation ball sponsored by the Young Men's Business Club of Moss Point.

LAWRENCE S. GOLDSTEIN of Jackson announces the opening of his office for the practice of obstetrics and gynecology at Lakeland Clinic for Women, 1044 North Flowood Drive.

CHARLES M. HEAD of Jackson announces the limiting of his practice to gynecology at Lakeland Clinic for Women, 1044 North Flowood Drive.

S. S. KETY of Picayune has been presented a special appreciation plaque by the George B. Boland Nurses scholarship fund, a national fund which was started by Dr. Kety and now sponsors 29 nursing scholarships.

MARION J. LEDOUX of Gulfport has been elected senior vice president and medical director of Pan-American Life Insurance Company of New Orleans.

ROBERT ASHFORD LITTLE of Gulfport was one of six Coast businessmen who reigned as dukes of the Gulf Coast Carnival Association's 51st annual Mardi Gras celebration.

FRANCIS S. MORRISON of Jackson and UMC attended the Council of Community Blood Centers and American Red Cross meeting in Atlanta, presented three lectures, and participated on a volunteer blood donor recruitment panel. He was re-elected CCBC trustee and named to represent the council at the American Blood Commission meeting.

A. T. NADEAU, JR. of Grenada announces his retirement from the practice of medicine.

WILLIAM T. OAKES of Amory talked on "Stress Testing the Heart" during the 6th annual education symposium of the American Association of Medical Assistants, Mississippi Society.

PRAVIN P. PATEL, a native of Uganda, has associated with R. T. HOLLINGSWORTH in Shelby.

GILBERT O. SPENCER of Columbus is new president of Prairie Medical Society. T. N. BRADDOCK of West Point is president-elect and GEORGE WALKER of Starkville is secretary-treasurer.

CHARLES C. TYLER of Collins has been named to the board of directors of State Bank and Trust Company of Collins.

W. W. WALLEY of Waynesboro was guest speaker at the University Baptist Church in Hattiesburg. He led a seminar on malnutrition for youth and spoke on Christian citizenship.



LETTERS

SIRS: In response to the article "Medicaid's Program for Children Called a Disgrace," JOURNAL MSMA, January 1977, I would like to point out that, first of all, the study referred to in this article did not involve an adequate sample from Mississippi. State-wide, Mississippi's EPSDT program screened 57,081 Medicaid eligible children during the past fiscal year, 51,575 of whom were referred for further diagnosis and treatment. This is approximately one-third of the estimated 173,000 eligible children in the state. Almost two-thirds, 102,834, were appointed for screening services. Considering that this is a voluntary program and Medicaid recipients are not required to participate, the resulting number that received screening services was very good. Another factor contributing to the lower show rate than appointments is the availability of crisis care services under the regular Medicaid Program. Keep in mind that Mississippi is a rural state and many of its residents are not aware of the value of preventive health services. The number screened is a very positive indication of the effectiveness of our outreach efforts.

Mississippi's EPSDT program provides all of the screening services as set forth in the guidelines by the Department of Health, Education, and Welfare. There is a provision for eyeglasses, hearing aids, and dental corrections where warranted, in addition to the regular dental program for extractions. Followup for diagnosis and treatment is limited by the availability of treatment resources. In Mississippi, as is nationwide, private health care providers are not required to provide services to Medicaid recipients.

In closing, I would like to say that Mississippi's EPSDT program is fulfilling its obligation to the state's Medicaid children in as much as health resources which are very limited in many parts of the state will permit.

ERNEST GRIFFIN, Supervisor EPSDT
(Medicaid Screening Program)
Mississippi State Board of Health



POSTGRADUATE CALENDAR

April 11-15, 1977

NEWBORN CARE FOR PHYSICIANS (ADVANCED
COURSE)

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine and the University Medical Center Division of Continuing Health Professional Education, with support from the Bureau of Community Health Services, Department of HEW.

Coordinator:

Gwendolyn Bussa, M.N., assistant professor of nursing, University of Mississippi School of Nursing, and instructor in obstetrics-gynecology, University of Mississippi School of Medicine.

The content of this course is drawn from the material covered in the basic course. Attendance at a physician's basic session is required. Emphasis will be on the clinical application of previous instruction. Fee: \$125. Credit: 40 contact hours, 4 CEU, Category 1, AMA; AAFP.

April 11-15, 1977

PULMONARY MEDICINE INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and University Medical Center Division of Continuing Health Professional Education, with support from the Mississippi Regional Medical Program.

Coordinators:

Joe R. Norman, professor of medicine and Christmas Seal Professor of pulmonary disease, University of Mississippi School of Medicine; director, UMC pulmonary division; and UMC associate professor of physiology-biophysics.

A. Wallace Conerly, M.D., assistant professor of medicine, University of Mississippi School of Medicine, and director, UMC respiratory therapy.

Routine pulmonary evaluation and function testing will be taught in this one-week course. Lectures will cover a variety of pulmonary disorders and therapy techniques. Registrants will also participate in daily rounds. Fee: \$125. Credit: 40 contact hours, 4 CEU, Category 1, AMA; AAFP.

April 20, 1977

EARLY DETECTION OF HEAD AND NECK CANCER
Holiday Inn Northeast, Meridian

Sponsored by the University of Mississippi School of Nursing, University Medical Center Division of Continuing Health Professional Education and National Cancer Institute Project for



Board of Trustees Handles Full Agenda at Winter Meeting

The association's Board of Trustees held its regular winter meeting on March 17 and considered a large agenda of business to include the annual audit, State Board of Health appointments and reports to the House of Delegates at the 109th Annual Session to be conducted May 2-5 at Biloxi.

After consideration of inflationary trends and the status of current and future association activities, the Board voted to seek a \$75 increase in dues effective in 1978. The Board noted that with the dues increase the association would remain in the bottom third of dues charged by state medical associations.

The Board also acted to retain legal counsel to do all that was necessary to see that the Mississippi State Board of Health was legally constituted. The Board received a suit filed by the Governor against the association in this regard and accordingly noted that the association's role in the matter was to abide by a law passed by the Mississippi Legislature, namely to make nominations to the Governor for appointments to the Mississippi State Board of Health.

In other business, the Board reviewed its annual reports and the annual reports of other association councils to the House of Delegates at the 109th Annual Session.

The Board noted and approved plans of the

Speaker and Vice Speaker to mail all annual reports to members of the House of Delegates prior to the annual session and to limit business before the opening session of the House of Delegates to the president's annual address, recognition and remarks from distinguished guests, and introduction of late resolutions or reports of an emergency nature.

The Board also voted to recommend to the House of Delegates that an interns and residents business section be established as one of the section meetings conducted at the annual session. The section would be financially supported by the association to the same extent as the other sections and the Board will encourage the section to present programs on medical socioeconomic issues.

Serving as members of the Board of Trustees during the 1976-77 association year are: Drs. Robert S. Caldwell, Tupelo, chairman; Arthur A. Derrick, Durant, vice chairman; Gerald P. Gable, Hattiesburg, secretary; Whitman B. Johnson, Jr., Clarksdale; John R. Lovelace, Batesville; Carl G. Evers, Jackson; Max L. Pharr, Jackson; Joe S. Covington, Meridian; Sidney O. Graves, Natchez; Paul H. Moore, Pascagoula; Lyne S. Gamble, Greenville, president; and Jack A. Atkinson, Brookhaven, immediate past president.

POSTGRADUATE CALENDAR *(Continued)*

Head and Neck Cancer, in cooperation with the American Cancer Society, Mississippi Division, Inc.

Coordinator:

Dale E. Clark, M.M.S., Mississippi Head and Neck Cancer Network, University of Mississippi Medical Center.

Open to physicians, dentists, RNs, LPNs, dental hygienists and dental auxiliaries, this workshop is one in a series planned to give health professionals new information about head and neck cancer, with emphasis on early detection, coordinated treatment and total rehabilitation. Fee \$10. Credit: 6 contact hours, .6 CEU, Category 1, AMA; AAFP.

History of Medicine Society Meets

The spring meeting of the University Medical Center History of Medicine Society is set for Thursday, April 14, at 7:00 p.m. in the Conference Room of the Medical Alumni House, UMC.

Speaker will be Peter Stewart, Coordinator of Minority Student Affairs, UMC, who will talk on "Black Contributions to Mississippi Medical History."

Cost is \$7.50 and there will be a social hour, dinner and program. Send reservations and checks payable to History of Medicine Society to: Dr. Ojus Malphurs, Communicative Disorders Lab, UMC, 2500 N. State St., Jackson, MS 39216. Anyone with an interest in medical history is invited to attend.

Dr. Hoyt Gardner Is N.E. Miss. Society Speaker

Dr. Hoyt D. Gardner, AMA Trustee from Louisville, Kentucky, addressed the March 3, 1977, quarterly meeting of the Northwest Mississippi Medical Society in Tupelo.

Dr. Gardner discussed the AMA's programs and activities noting that the AMA was the largest professional organization of physicians in the world with a membership total at this time larger than at any time in the history of the association.



Dr. Gardner

"Every program and policy of the AMA has evolved from a county medical society, through a state medical association, through the AMA House of Delegates which is elected by the state associations," Dr. Gardner stated. "We are a democratic organization and as with any such organization you shouldn't expect 100 per cent agreement 100 per cent of the time," Dr. Gardner continued.

Dr. Gardner further noted that the AMA Board of Trustees was composed entirely of practicing physicians.

Also in attendance at the meeting were Dr. Lyne Gamble of Greenville, MSMA president, and other officers of the association.

MSMA Is Favored in Chiropractic Suit Decision

A Hinds County Chancery Court has ruled that the use of microwave diathermy, ultrasonic devices, electric muscle stimulators and the prescribing, recommending or suggesting of vitamins and food supplements by a chiropractor is the practice of medicine and is illegal.

The suit which was filed by MSMA last year was cited as a "landmark case." As JOURNAL MSMA went to press, the defendant in the case had not announced whether the court's decision would be appealed.

Annual Re-Registration of Licenses Announced

Applications for annual renewal of medical licenses will be mailed this month. The application must be completed and returned to the Office of Medical Licensure, Mississippi State Board of Health, with your check for \$10.00.

The signature and fee have frequently been overlooked by the practitioner and special attention is directed to this area. Please remember that if your completed application (including signature and fee) is not received in the Board Office prior to June 30, 1977, you will be practicing in Mississippi without a license.

If your address has changed during the renewal year, please contact the SBH office so that you will receive this notification.

Surgical Forum Guest and Coordinators Confer



Guest faculty member Dr. G. Tom Shires, left, professor of surgery and department chairman, Cornell University Medical College, New York City, discusses the program for the University of Mississippi Medical Center Postgraduate Surgical Forum IV with seminar coordinators Dr. William O. Barnett, center, UMC professor of surgery, and Dr. James D. Hardy, right, UMC professor of surgery and department chairman. The annual event is sponsored by the University of Mississippi School of Medicine and UMC Division of Continuing Health Professional Education. Dr. Shires was also Alpha Omega Alpha visiting professor at UMC the week of the Surgical Forum and guest of honor at a Jackson Surgical Society dinner.

Mississippi Surgeons Attend UMC Seminar



Among the Mississippi surgeons at the University of Mississippi Medical Center Postgraduate Surgical Forum IV were (seated, from left) Dr. Mayo Flynt of Meridian and Dr. Jack A. Atkinson of Brookhaven and (standing) Dr. George Gillespie of Jackson and Dr. H. T. Whitaker of Greenwood. More than 300 surgeons from 34 states heard 11 noted surgeons and Medical Center faculty discuss general, pancreatic and malignant disease problems at the March 10-12 seminar.

South Miss. Med. Society Gives to Guyton Fund

The South Mississippi Medical Society has contributed \$500 to the Billy S. Guyton, M.D., Memorial Medical Education Loan Fund at the University of Mississippi Medical Center.

Established in 1972, the Guyton Fund is a joint effort of the Mississippi State Medical Association, the University of Mississippi Medical Alumni Chapter and the Medical Center. Contributions through the three member agencies, and other interested individuals or organizations, support the ongoing fund.

The society's contribution will provide needed loan monies for state medical students, according to UMC Vice Chancellor and School of Medicine dean Dr. Norman C. Nelson. Dr. Richard Campbell of

Columbia is president of the medical group.

"The South Mississippi Medical Society is to be commended for its generous gift to the Guyton Fund," Dr. Nelson said. "The fund was created to honor one of Mississippi's most distinguished medical educators and to give financial assistance to medical students for generations to come. This gift will provide an educational loan for a future state physician."

Dr. Guyton was dean of the Mississippi medical school from 1935-1944, when he was named dean emeritus. He headed the Guyton Clinic in Oxford until his death in 1971 at the age of 87.

An ear, nose and throat specialist, Dr. Guyton was a fellow of numerous organizations and a former president of the Mississippi State Medical Association and the Louisiana-Mississippi Ophthalmology-Otolaryngology Society.

AAFP Has Computerized Medical Records for CME

The *Mississippi* chapter of the American Academy of Family Physicians is one of 35 which has accepted an offer by AAFP headquarters to compile active members' continuing medical education records by computer.

This service provides members a more convenient method of reporting educational activities, plus the advantage of having records accessible when needed to determine the accrued total. The member also will be able to authorize their being reported to another medical organization. The system's feasibility has been established by a two-year pilot study involving five chapters.

Confidentiality of information is assured by a security system of special locks, access codes, and a matching identification number which corresponds to the first three letters of the last name. Information will be distributed to other agencies only upon documented request by the individual member.

On Mar. 15 AAFP headquarters will mail each participating member a packet containing 25 computer cards bearing his name and instructions. The packet will include 24 yellow cards to be used for reporting 1977 group or formal activities, and one green card for logging individual continuing medical education activities during 1977. The member should take the yellow card to each CME course. After completing each course, the yellow card must be turned in to the course sponsor, who will in turn send all cards from participating academy members to AAFP headquarters.

AAFP RECORDS / Continued

It is essential to use only the yellow or green cards when reporting attendance at activities and courses. Only data from these forms can be fed into the computer. Continuing education information received on letters, cards or registration forms complicates the data entry system and can jeopardize the accuracy of the records. If the cards are used, records will be accurate, up-to-date and rapidly available for distribution upon request.

The cards become a part of the permanent computer records which will be updated every 10 days. By using the on-line equipment, the headquarters staff can supply a copy of the member's records at any time upon request. Copies of the record will be mailed to each member and to his chapter semi-annually for review and evaluation.

A Department of Computerized Medical Records has been established at AAFP headquarters to handle the work load arising from this new system. Please write or call this department (on Watts number 800-821-2512) if there are questions.

Arthritis Foundation Gives Grant to UMC

The Mississippi Chapter of the Arthritis Foundation has awarded a University of Mississippi Medical Center physician \$30,685 to establish a new laboratory at the Medical Center.

Dr. James Pennebaker, assistant professor of medicine and director of the rheumatology division, will use the funds to equip the only diagnostic and research rheumatology laboratory in the state.

The foundation grant comes from the estate of the late Jackson artist Ethel Elizabeth Ketcham who wanted the sum to "be expended after careful deliberation for some worthwhile and needed item or items of property to benefit arthritis patients."

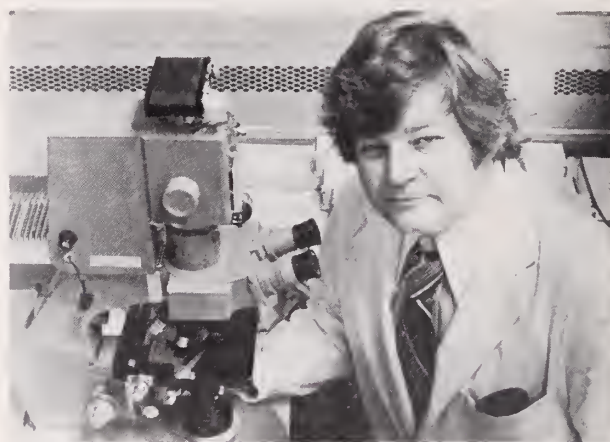
Miss Ketcham, who died in 1965, was a charter member of the Allison's Wells Art Colony in Canton and painted actively even after arthritis crippled her hands.

Dr. Pennebaker's research will focus primarily on the immunologic aspects of both rheumatoid arthritis and systemic lupus erythematosus (SLE). He will try to determine what factors in SLE patients make them a risk for central nervous system inflammation. From tissue samples of rheumatoid arthritic surgery patients, he wants to study the immune response occurring in the synovium of affected joints.

The Arthritis Foundation grant will buy a spectro-

photometer, a preparative ultracentrifuge, and a liquid scintillation counter for the laboratory, already equipped with a fluorescent microscope.

Dr. Pennebaker is a UMC graduate and completed a medicine residency at the Medical Center in 1974. Until his current appointment, he was a rheumatology fellow at Southwestern University Medical School in Dallas, TX.



A grant from the Mississippi chapter of the Arthritis Foundation to Dr. James B. Pennebaker, UMC assistant professor of medicine and director of the rheumatology division, will help equip a rheumatology laboratory at the Medical Center. Already equipped with a fluorescent microscope, the lab will have a spectrophotometer, a preparative ultracentrifuge, and a liquid scintillation counter.

Dr. O. H. Anis Named to Medical Center Faculty

Dr. Onssy Hanna Anis has been named assistant professor of radiology at the University of Mississippi School of Medicine.

His appointment was announced by Vice Chancellor Dr. Norman C. Nelson following approval of the Board of Trustees, Institutions of Higher Learning.

Dr. Anis comes to the Mississippi medical center from the University of Missouri School of Medicine faculty. He earned his medical degree from Cairo University, Cairo, Egypt, in 1960 and completed internships at Ahmed Maher Hospital, Cairo, and Fitkin Hospital, Neptune, N. J.

He took his specialty training at Jamaica Hospital in Jamaica, Hackensack Hospital in Hackensack, N. J., and Albert Einstein College of Medicine Hospital, Bronx, N. Y. Dr. Anis worked as a public health officer from 1961-1968 in Egypt and did research at Rancho Los Amigos Hospital, Downey, Calif., in 1969.



CLASSIFIED

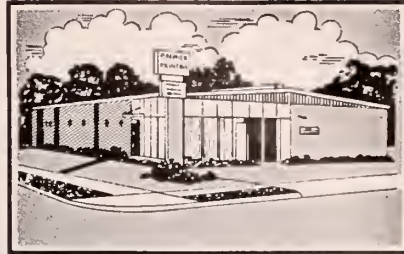
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IN CONCLUSION

The Metropolitan Life Insurance Company's annual study on mortality shows that the U.S. death rate dropped below nine per 1,000 in 1976 -- for the first time in the nation's history. Final figures are expected to show that the death rate was approximately 8.8 per 1,000. The heart disease death rate dropped fractionally and cancer death rate dropped about 1 per cent. The pneumonia/influenza death rate, which tends to fluctuate yearly, went up 11 per cent in 1976 but the infant mortality rate dropped from 16.1 to 15 per 1,000 live births.

Women aged 40 and over may be able to continue pill use with relative safety if they do not smoke cigarettes or have other conditions which predispose them to heart attack, according to Family Planning Perspectives. However, women as young as 30 who cannot give up smoking probably should not take oral contraceptives because of greatly multiplied risk of fatal heart attack associated with interaction of these two factors, says U.S. C.D.C. Of the major risk factors, smoking is more important than high cholesterol levels or hypertension.

Advanced therapy is available now to cure half the cancer patients in the U.S., according to Dr. S. K. Carter, director of the Northern California Cancer Program. The problem is to bring the existing advanced therapy to every patient, he says. "About one-third of the people who develop cancer in this country can be cured and are being cured," Dr. Carter said. Cancer scientists are trying to learn how to cure the 50 per cent not capable of cure now, and they say the need for a fast and reliable diagnosis system is great.

The Center for Disease Control in Atlanta reported in the Jan. 31 issue of JAMA the death rate for legal abortion in the U.S. for three years, 1972-74. Records on almost 2,000,000 legal abortions were analyzed. Death rate averaged 3.9 for each 100,000 legal abortions. Death rate for continuing pregnancy and childbirth during the same three years was 14.8 per 100,000 live births. Duration of pregnancy was the most important risk factor. Abortions in the first three months of pregnancy had a death rate of 1.7 per 100,000.

The nation's commercial airlines carried a record 220 million passengers during 1976, says the Federal Aviation Agency, with the lowest accidental death toll -- 45 people -- recorded for more than 20 years. Thirty-eight of those 45 persons died in a crash last April in the Virgin Islands. The 1976 number compares with 124 deaths from airliner crashes in 1975 and 464 in 1974. Business and private airplane accidents killed 1,188 people in 1976, compared to 1,280 fatalities in 1975.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psycho-

tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

ship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. **Oral—Adults:** Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* **Geriatric patients:** 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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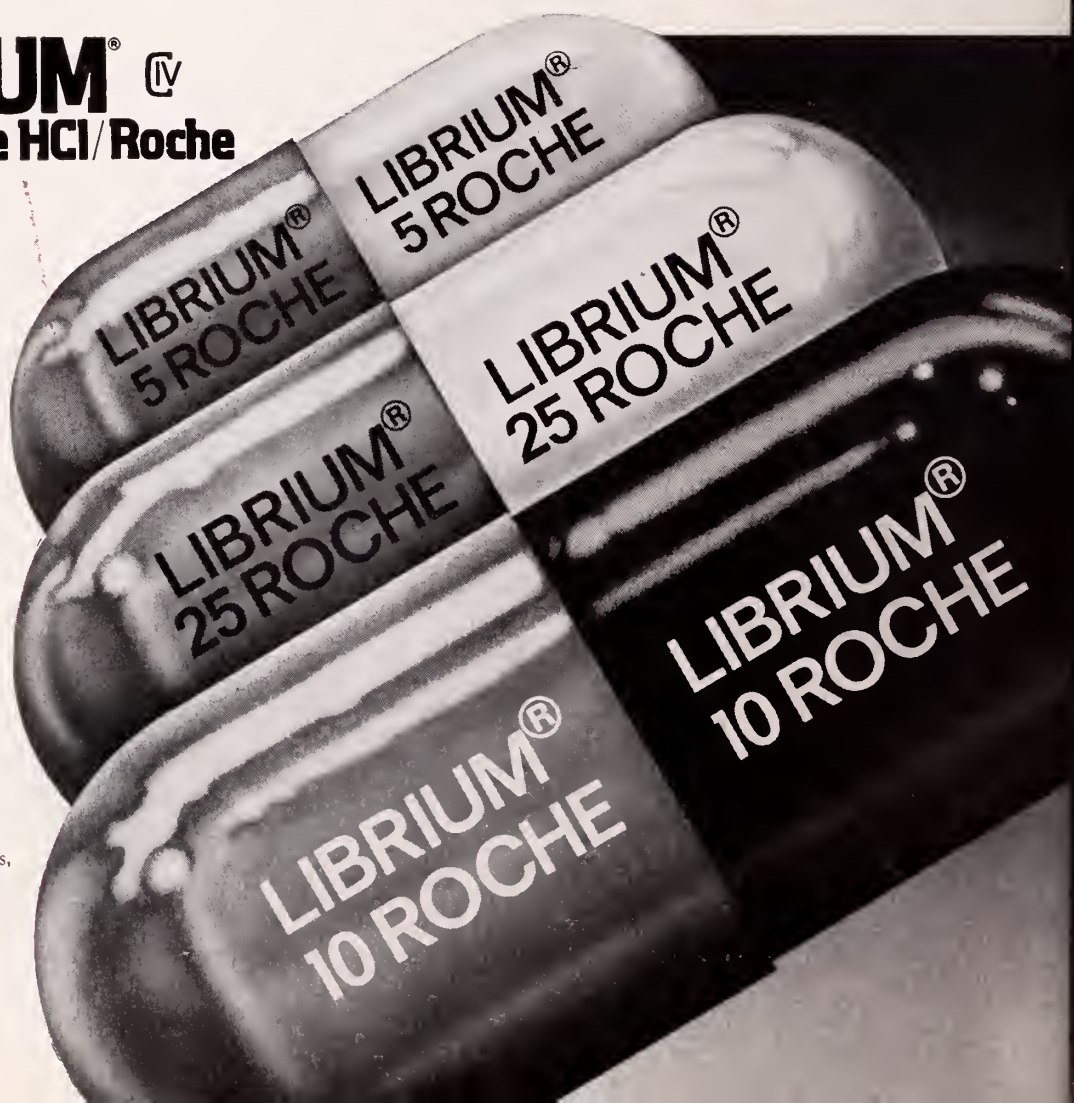
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Please see preceding page for a summary of product information.

May 1977

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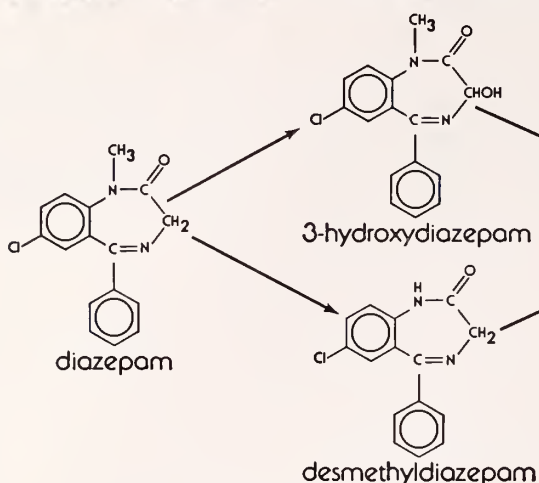
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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due

to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated:

Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients.

Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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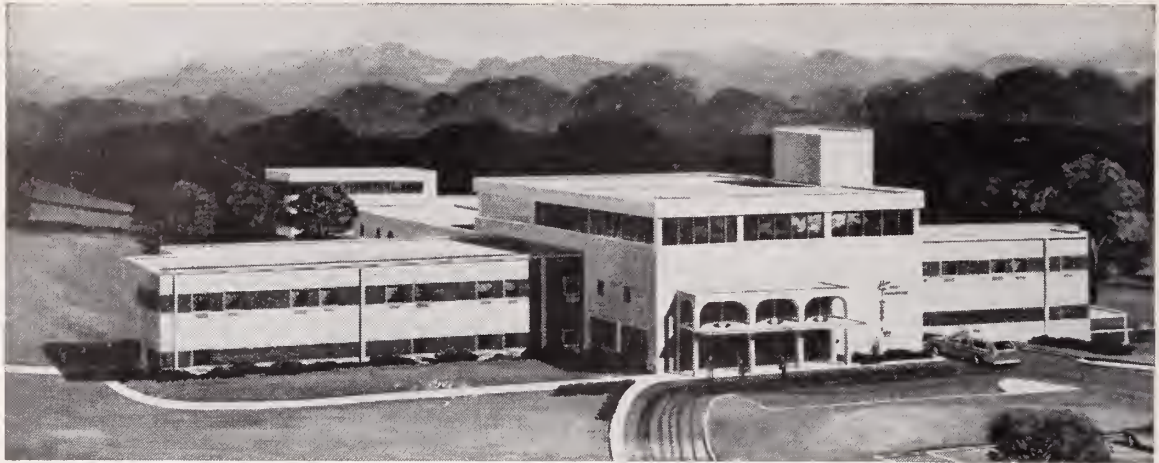
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Volume XVIII

Number 5

May 1977



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$15.00 per annum; \$2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital, the alcohol content is 15%.

See next page for brief summary.



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Description. Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

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Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

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Tedral Elixir is convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

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Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to *one-quarter* Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

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Doctors Are Practicing "Defensive Medicine"

Three out of four American physicians are practicing "defensive medicine"—that is, ordering extra tests and procedures for patients—as a protection against potential malpractice suits, according to an American Medical Association poll. And the medical bills of the patients are increasing as a result.

More than 90 per cent of the poll respondents indicate they are more conscious today than in the past that they may later be sued for malpractice.

A sizeable number of the doctors say they are ordering one or two extra tests—x-rays, laboratory tests, other diagnostic procedures, and some are ordering three or four more tests.

Not only are patients paying for more tests, but three out of five doctors say they had raised their own fees in the last year because of increasing malpractice premiums.

Physicians Rank High In Public Perception

When asked to rate the ethical standards of 11 professional groups and the credibility of their organization, Americans show by a large majority that they trust the American Medical Association.

This conclusion is drawn from 1976 studies conducted by the Gallup Organization, Inc., of Princeton, N. J., and published in the Impact section of *American Medical News*, the weekly newspaper for physicians of the AMA.

In the area of believability, the AMA ranked 6.8 on a scale of 1 to 10. Other groups ranked were news media, 6.1; business corporations, 5.0, and labor unions and federal agencies, 4.9 each, the Gallup Organization found.

In the public's perception of honesty and ethics, physicians were ranked 56 per cent "very high" or "high." Following were engineers, 49 per cent; college teachers, 44 per cent; journalists, 33 per cent; lawyers, 25 per cent; building contractors, 23 per cent; business executives, 20 per cent; senators, 19 per cent; congressmen, 14 per cent; labor union leaders, 12 per cent, and advertising personnel, 11 per cent.

Although the public shows a high regard for physicians, a disturbingly large proportion of the population does not share this view. Physicians are held in higher esteem than the other 10 occupations tested, but 44 per cent of the public does not feel that physicians are highly ethical and honest.

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no interference in the management of the diabetic patient has been reported with

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Possibly Effective:

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2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg. per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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NEWSLETTER

May 1977

Dear Doctor:

The American public received an estimated \$35.8 billion in private health insurance benefits in 1976, reports Health Insurance Institute. This was an increase of more than \$4 billion over 1975, a 13 per cent gain and a record for benefits paid during a single year. Americans are receiving an average of \$98 million in benefits every day from private insurers to help meet medical bills. Insurance companies paid out \$15 billion in medical and dental expenses in 1976.

There are now an estimated 183 million people in the U.S. with some form of private health insurance. Year-end health insurance coverage estimates for 1976 show a gain of nearly 5 million insured people, an increase of 3 per cent over the previous year. Greatest increase was in hospital expense insurance.

The Mississippi Medicaid Commission has reversed itself and placed vasodilators and arthritic drugs back on its pharmaceutical formulary. The removal of the drugs last summer drew heavy fire from civil rights group whose activities included a march on the Capitol when the state legislature convened in January. The commission had removed the drugs in an effort to reduce program costs.

The Mississippi Medical Fraternal and Educational Society is accepting applications for membership. The association-sponsored society will provide professional liability coverage for its members. The initial membership fee of \$1,000 is only applicable to this enrollment period and can be expected to increase in the future, say society officials.

Again on the professional liability insurance crisis, a Jackson obstetrician-gynecologist is shaking his head over the bill he recently got for the reporting endorsement under a claims made policy. It amounted to \$6,000!! Reporting endorsement which is available to claims made policyholders upon retirement covers claims incurred but not reported during claims made policy period.

The Mississippi Foundation for Medical Care, Inc. has released the following Mississippi data: 115 hospitals (12,039 beds) certified and participating in the Medicare and/or Medicaid programs; 108 hospitals (11,732 beds) implementing PSRO review; and 95 hospitals (10,489 beds) approved for binding review. For more information, write MFMC, P. O. Box 4665, Jackson 39216.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Most Planning Heads Came From Old CHPs

As predicted, most directors of the new local and state health planning bodies—HSAs and SHPDAs—come from the largely unsuccessful comprehensive health planning agencies (CHPs). The new agencies replaced CHPs under the health planning law (PL 93-641). Staffing information was collected from 192 HSAs and 47 SHPDAs.

The data shows 149 executive directors came from CHPs (local and state) with 18 who were formerly employed by one of the other programs replaced by the planning law, such as Hill-Burton and the regional medical program. Only 14 directors have backgrounds in providing health services (hospital administrators, public health physicians or other direct health services).

The rest came from local government (5), regional planning bodies (7), universities (3) and other professions (8). The greatest percentage of directors receive salaries in the range of \$25,000-29,999 (88); 79 directors are paid in the \$30,000-39,999 range. Eight make over \$40,000 and 13 receive under \$20,000 a year.

Sixty-two HSAs surveyed had the minimum number of professional staff required for full designation under the health planning law, and 46 have nearly met the requirement. The largest number of professional staff are reported in the "health planning" category with the smallest number in "resources development."

The data collected at the end of 1976 also showed that only 23 HSAs are using consultants.



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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

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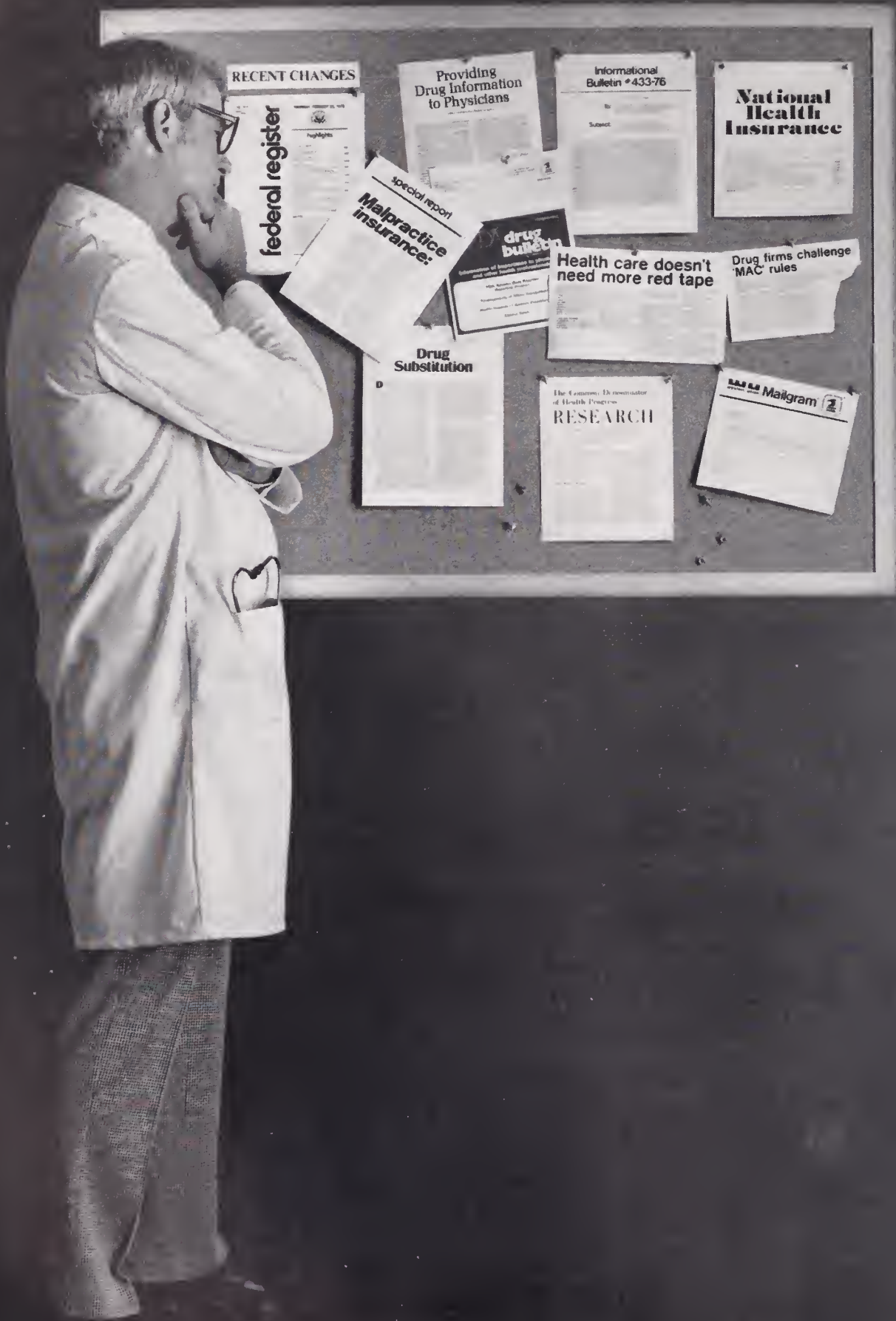
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Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

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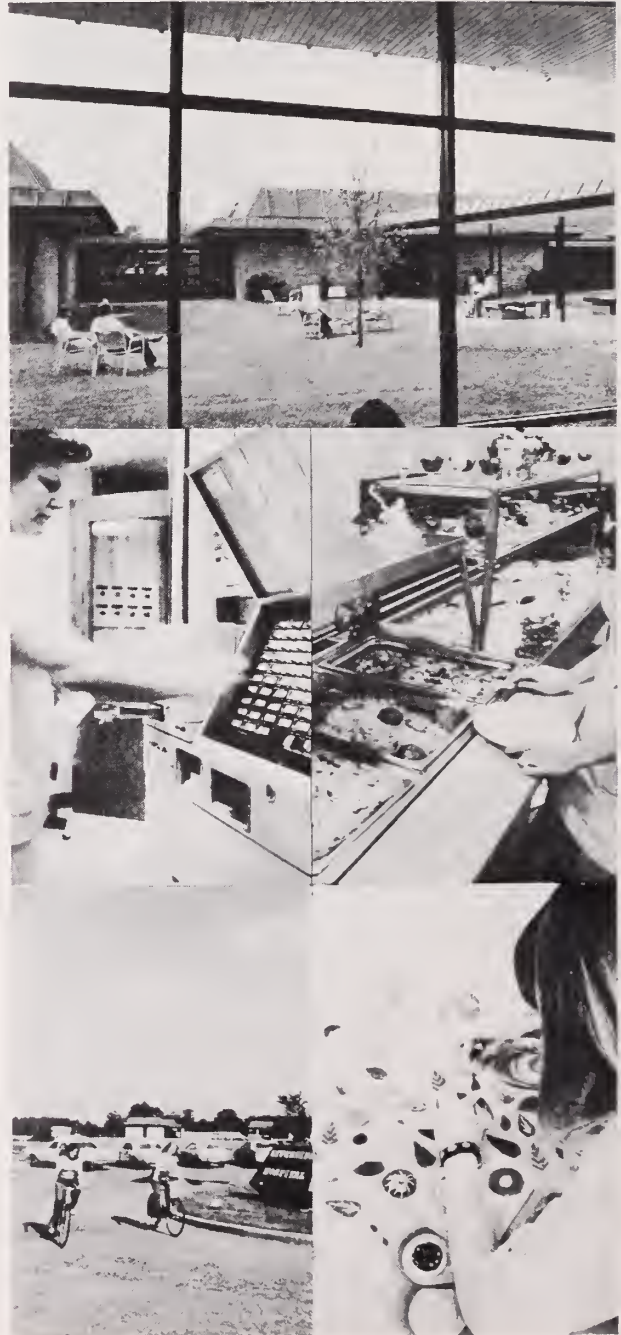
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For additional information contact: John R. Reedy, Executive Director.

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DATELINE

MSMA Is No Longer CHAMPUS Administrator Jackson, MS - Effective June 1, 1977, the state medical association (MSMA) will no longer serve as fiscal intermediary for professional services under Civilian Health and Medical Program of the Uniformed Services in Mississippi. In an "economy" move, CHAMPUS has sought multi-state and regional administrators. Blue Cross - Blue Shield of Mississippi, Inc. will serve as CHAMPUS fiscal intermediary for Mississippi and Louisiana.

Unethical Physicians Are Studied San Francisco, CA - Speakers at a recent AMA Conference on the Impaired Physician stated that common characteristics of the "unethical physician" were excessive charges, excessive utilization of diagnostic or therapeutic modalities and utilization of therapeutic regimens of questionable scientific validity. "They are a severe problem to the profession because the practices involved may be legal and professional sanctions have little or no impact."

Health Foods May Be Harmful to Children Evanston, IL - The American Academy of Pediatrics' Committee on Nutrition has expressed concern about "the recent increase in nutritional practices that are potentially hazardous to the health of children," including the overuse of certain vitamins and the use of a Zen Macrobiotic diet for growing children. Problems cited with vegetarian diets are the tendency to be so high in bulk that they may not need meet caloric needs and the failure to supply adequate protein.

Venereal Disease in Mississippi Reported Jackson, MS - Reported cases of gonorrhea in Mississippi totaled 16,653 for fiscal 1976, according to the State Board of Health. This represents an increase of 9.02 per cent over 1975. Male to female ratio was 1.26:1. Reported early syphilis morbidity decreased during 1976. Hinds County reported 34 per cent of the state's early syphilis morbidity during fiscal 1976. Preventative treatment was administered to 1,256 syphilis contacts.

Dentist Manpower in State Studied Jackson, MS - Mississippi has the lowest per capita supply of dentists among the 50 states. The Mississippi Dental Association and the U.S. Public Health Service recently conducted a survey of all practicing dentists in Mississippi. The Jackson metropolitan area had the highest concentration of dentists and the McComb - Hazlehurst areas had one of the lowest concentrations. Primary reason for choosing a practice location was available practice opportunity followed by family ties.

Thyroid Experts Nix Cancer-Hormone Link

The theory that thyroid supplements lead to breast cancer is unproved, and patients taking thyroid hormones should continue to take their medicine.

This is the conclusion of the American Thyroid Association in a special communication in the April 4 *Journal of the American Medical Association*.

A research report in the *AMA Journal* last September had indicated that breast cancer was high among individuals taking thyroid supplements. The report caused a flurry of anxiety in the hundreds of thousands of Americans whose thyroid output is lacking or inadequate, and whose doctors had prescribed additional doses of the important hormone.

A group of eight physicians from the Education Committee of the American Thyroid Association, headquartered at the Mayo Clinic, Rochester, MN, evaluated the September report as well as many other research reports on possible links between thyroid supplementation and breast cancer.

The doctors cited many gaps in the conduct of the September study that they felt invalidated its findings.

"In contrast to the highly tenuous nature of the relationship between thyroid hormone therapy and breast cancer, the adverse, and often serious, effects

of withholding specific therapy in patients with hypothyroidism are unquestioned," they said.

"The American Thyroid Association recommends, therefore, that patients who are taking thyroid hormones for well-established indications continue to take their medication." The association also called for more research to find a definitive answer.

Eyeglasses Price Fixing Charged

Optical retailers have charged that eyeglass prices are inflated because of state regulations that restrict competition between opticians and optometrists.

William Schuartz, vice president of Wall and Ochs, an East Coast Optical retailer, told a Senate subcommittee looking into eyeglass prices that state boards and state societies of optometrists and opticians exist for one reason "to artificially upgrade the business of selling eyeglasses into a professional status so one can hang a license on the wall and charge more for eyeglasses."

In Mississippi the executive director of the Mississippi Optometric Society, Helen St. Clair, was quoted as saying a "gentlemen's agreement" prevented advertising of prices by optometrists but that "we suggest that optometrists charge a \$26 professional fee for an examination and not mark up the price of glasses."

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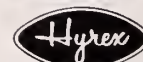
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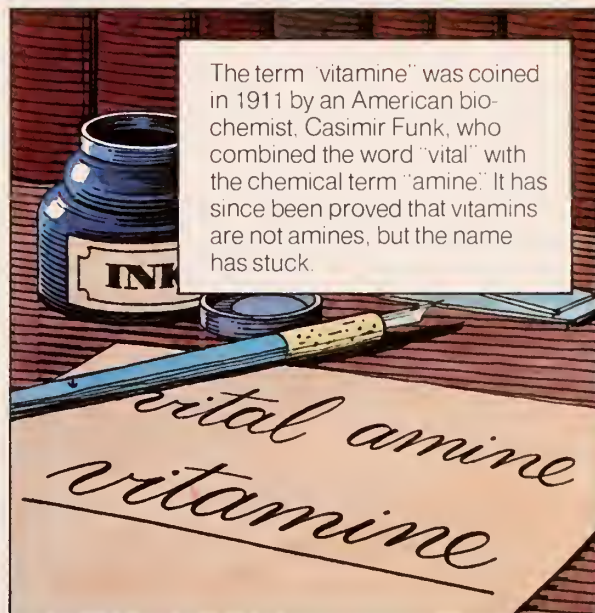
American Indians coveted fresh root tips and extracts of evergreen leaves in winter and onion-like bulbs and leaves in early spring to prevent the symptoms characteristic of vitamin C deficiency.



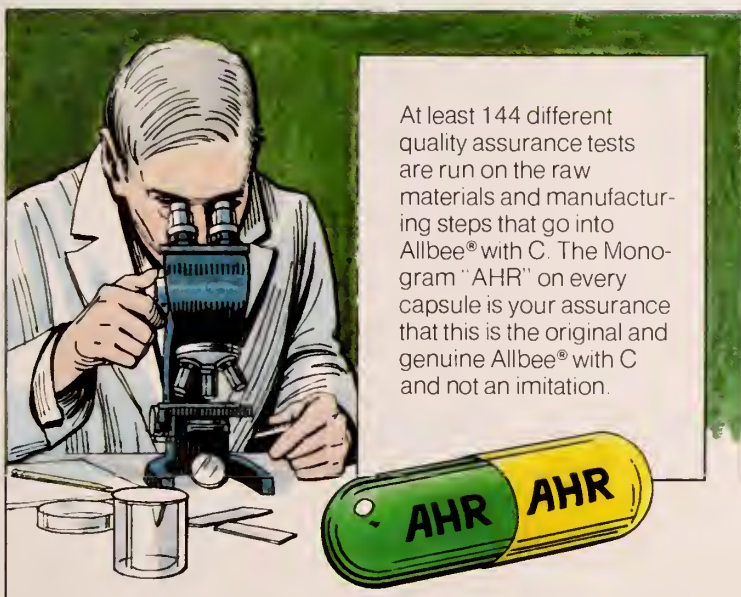
A tomato is botanically classified as a berry!



It is ironic that many of the vegetables highest in vitamin C and riboflavin are considered unappetizing by many people. These include turnip greens, kale, chard, mustard greens, spinach, water cress, broccoli and brussels sprouts.



The term "vitamine" was coined in 1911 by an American biochemist, Casimir Funk, who combined the word "vital" with the chemical term "amine." It has since been proved that vitamins are not amines, but the name has stuck.

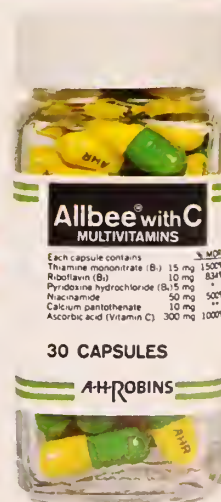


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Indications: Based on a review of this drug by the NAS/NRC and/or other information, FDA has classified the following indications as possibly effective: adjunctive therapy in the treatment of peptic ulcer; the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Brief summary. Contraindicated in patients with glaucoma, renal or hepatic disease, obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy) or a hypersensitivity to any of the ingredients. Blurred vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur at higher dosage levels, rarely at the usual dosage.

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Heart Associations Sponsor Cardiology Course

"Perspectives in Cardiology" will be the theme of the 1977 Tri-State Scientific Sessions for physicians to be held May 18-20 at the Broadwater Beach in Biloxi.

Sponsored by the Mississippi, Arkansas and Louisiana Heart Associations and the American Heart Association Council on Clinical Cardiology, the seminar will have 18 medical specialists as speakers.

The faculty for the 3-day event will include: Dr. F. Mason Sones, Jr., Cleveland Clinic, Cleveland, Ohio; Dr. Tom Killip, Evanston, IL; Dr. John Ochsner, Dr. Jeffrey P. Bower, and Dr. Noel Mills, all of Ochsner Foundation Hospital, New Orleans; Dr. Richard Jaffe, Seattle; Dr. James E. Doherty, University of Arkansas School of Medicine; Dr. Edward B. Stinson, Stanford University Medical Center, Palo Alto, CA; Dr. Thomas Sharpe, University of Mississippi; Dr. Robert S. Lees, Mass. General Hospital, Boston; Dr. James Crostwait, Dr. Jeff Hollingsworth, both of Jackson; Dr. Kenneth Bennett, Dr. David G. Watson, Dr. Harper K. Hellums, Dr. Patrick Lehan, Dr. Arthur C. Guyton, and Dr. Herbert G. Langford, all of UMC.

The sessions are acceptable for 14 hours of credit toward the AMA Physician's Recognition Award and for 14 elective hours by the AAFP.

Dr. Quinton Dickerson of Jackson is seminar chairman. Further information and registration forms are available from the Mississippi Heart Association, Box 16063, Jackson, MS, telephone 981-4721.

Med Students Receive \$7.8 Million From AMA-ERF

Approximately 6,000 medical students and physicians-in-training borrowed \$7.8 million in 1976 from the American Medical Association Education and Research Foundation student loan program to help meet medical education expenses.

Loans to medical students (5,055) accounted for 91 per cent of all loans made through the AMA-ERF program last year. Since the program began in 1962, more than \$77 million in loans have been arranged and guaranteed by the AMA-ERF.

A \$13,422.20 unrestricted AMA-ERF grant has recently been presented to the University of Mississippi School of Medicine. The funds represented contributions to AMA-ERF from Mississippi physicians and their wives during 1976.

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Federal Health Chiefs Are Named

The Carter administration has recently filled three top health positions.

The new Commissioner of the Food and Drug Administration is Donald Kennedy, Ph.D., a neuro-physiologist from Stanford University. Dr. Kennedy is the first non-physician to head the agency in 11 years but he doesn't place much significance in that fact.

"I've been active in the community of neuro-physiologists for some time. About half my colleagues who are good scientists have M.D.s, the other half have Ph.D.s. If I didn't know something about their personal histories I wouldn't know, from their ability to do what they do, which was which. In other words, you can be a good scientist with either degree. Furthermore, I don't think an M.D. confers you with an automatic set of prejudices about regulation either."

HEW Secretary Califano praised Dr. Kennedy in announcing the appointment and said "it is imperative that the FDA act only in the public interest

and with much greater dispatch than it has in the recent past."

Christopher C. Fordham, M.D., dean of the University of North Carolina Medical School, is the choice of the Carter Administration as Assistant Secretary for Health at HEW.

The naming of the federal government's top health official had been the subject of much speculation and interest over the past weeks. The selection of the Assistant Secretary for Health (ASH) in a new administration is considered an important guide to the type of health policies HEW will pursue.

Dr. Fordham, 49, is a board certified internist and a member of the AMA. He received his medical degree from Harvard University Medical School. He is well-known in North Carolina and is regarded generally as a moderate on socioeconomic medical issues.

Thomas D. Morris was named to the newly created post of Inspector General of HEW. The job was established by Congress last year to oversee a \$25 million program, to find fraud and abuse in various HEW programs, especially Medicaid. Morris will have a staff of 1,000 auditors and 100 investigators.

Morris, 63, was Assistant Secretary of Defense

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in charge of the cost reduction program and procurement operations from 1961 to 1968 and was Assistant Comptroller General from 1970 to 1975. For the past year, he has been a senior staff member of the Brookings Institution in Washington.

Morris will focus initially on the broad area of health care services, including alleged widespread fraud in the Medicare and Medicaid programs, and the student loan programs.

Morris will be responsible both to the HEW Secretary and to Congress. The importance of the post was underlined by having the announcement of Morris' appointment come from the White House rather than the Secretary's office.

AMA Urges Laetrile Testing

"Quality patient care would suffer if laetrile were made available without compliance with the law," the AMA emphasized in a statement to the Food and Drug Administration. The association added that "a greater, and more tragic, safety factor exists" concerning the use of laetrile, "a factor not often considered in the law. . . . This factor pertains to exploitation of the cancer patient by the purveyor of a worthless treatment modality." The AMA submitted its comments in response to a notice published in the *Federal Register* concerning the FDA's intent to determine whether laetrile is a "new drug" and, if so, whether it would be exempt from the pre-marketing approvals otherwise required for a "new drug."

The AMA said it supports the FDA's contention that laetrile is a "new drug" and said it "should be subjected to the requirements of the law for approval." The statement cited a House of Delegates action at the 1976 Clinical Convention giving the profession's view of laetrile and added that the substance "is not generally recognized by experts qualified to evaluate the safety and effectiveness of drugs as safe and effective." Laetrile should not be distributed in interstate commerce, the AMA said, "until such time as its safety and efficacy for the treatment of cancer have been established through controlled pre-clinical and clinical experimentation."

During the recent session of the Mississippi Legislature a bill was introduced but not passed which would have "legalized" the use of laetrile in Mississippi. Such legislation has been introduced in other states by the "Laetrile Lobby."

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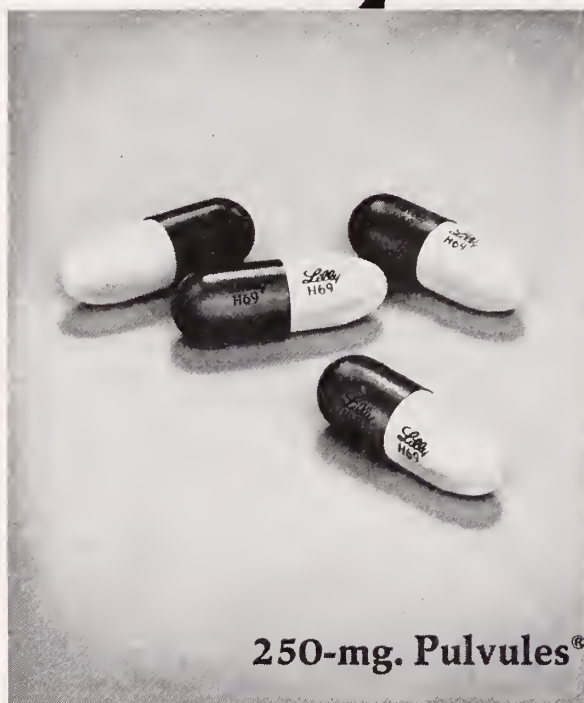
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ORIGINAL PAPERS

Peritoneal Dialysis: A Review

MARCELO J. RUVINSKY, M.D., JOHN D. BOWER, M.D.

ROBERT D. HOLBERT, M.D., and THOMAS D. WOOLDRIDGE, M.D.

Jackson, Mississippi

PERITONEAL DIALYSIS was first considered by Ganter¹ in 1923. In the late 1950's, its clinical use became widespread following the introduction of commercially available dialysis fluid.² In the mid 1960's, peritoneal dialysis began to be eclipsed by the more efficient and better tolerated hemodialysis. In the last few years, however, peritoneal dialysis has been reevaluated and is increasingly regarded as the method of choice in many situations requiring acute dialysis. Chronic maintenance peritoneal dialysis is also gaining popularity and acceptance, and is considered to be the procedure of choice for chronic dialysis in certain groups of patients,³⁻⁷ such as those with angina pectoris and diabetes mellitus. The simplicity of peritoneal dialysis may offer advantages in those groups of patients considered incapable of operating a hemodialysis machine.

For peritoneal dialysis, the peritoneum is considered to act as a semipermeable membrane across which certain substances may freely diffuse, according to the gradient established between the blood and the dialysate. By this method, undesired solutes and fluid may be removed and other solutes may be added. The technique is simple and can be performed in any hospital, requiring inexpensive equipment but adequate nursing care.

Indications for peritoneal dialysis are:

- A. Renal failure
- B. Acid-base corrections
- C. Electrolyte disturbances
- D. Drug intoxication or poisoning
- E. Others

A. Renal failure is the usual indication for peritoneal dialysis. If the patient is seen early in the course of progressive acute renal failure, dialysis should be started before complications develop. Uremic signs and symptoms (nausea, vomiting, hiccups, encephalopathy, pericarditis) call for immediate application of this mode of therapy. Fluid overload,

Peritoneal dialysis has been used in the treatment of acute renal failure for several decades. More recently, hemodialysis has become the most commonly used patient care modality. As the technique of peritoneal dialysis has been improved, with the introduction of automatic recycling machines and the development of safer, more permanent intra-peritoneal catheters, peritoneal dialysis has again become a useful tool in uremia control.

Peritoneal dialysis can be done in almost any hospital setting, provided nursing coverage is available. However, a general understanding of the technique and theory of peritoneal dialysis is necessary prior to clinical utilization. This review is intended to provide basic and important information concerning technique and physiologic mechanisms of peritoneal dialysis.

acid base imbalances, and electrolyte disturbances may, in certain circumstances, be the reason why the acute renal failure patient needs to be dialyzed.

B. Metabolic acidosis of any etiology may be treated by peritoneal dialysis if more conservative methods fail. This is accomplished by removing acid

From the Department of Medicine, Artificial Kidney Unit, University of Mississippi Medical Center, Jackson, MS.

radicals as well as by the absorption of bicarbonate from the irrigation fluid.

C. Life threatening hyperkalemia due to any causes (decreased excretion due to renal failure, accumulation secondary to rhabdomyolysis, etc.) calls for immediate intervention. Hyponatremia or water intoxication also responds readily to peritoneal dialysis.

D. Many poisons and drugs are removed by dialysis (see Table I). When the clinical situation dictates large amounts are to be removed rapidly, hemodialysis is the procedure of choice. Not every patient who suffers an overdose of a dialyzable drug should undergo immediate dialysis. Schreiner has suggested the following guidelines for deciding on dialysis.⁸

TABLE I
DRUGS REMOVED BY PERITONEAL DIALYSIS

<i>Antibiotics</i>	<i>Analgesics, Sedatives</i>
Chloramphenicol	Acetylsalicylic Acid
Carbenicillin	Cyclobarbitone
Cephalosporins	Phenobarbital
Colistimethate	Ethchlorvynol
Cycloserine	Meprobamate
Pyrizimide	Lithium
Para-amino Salicylic Acid	Methaqualone
Isoniazid	Amitriptyline
Chlortetracycline	Imipramine
Erythromycin	Nortriptyline
Dicloxacillin	Desipramine
Tetracycline	Amphetamine
Streptomycin	<i>Miscellaneous</i>
Kanamycin	Acetohexamide
Lincomycin	Methyl Alcohol
Neomycin	Ergotamine
Gentamicin	Chlorpropamide
Polymixin B	Boric Acid
Ethambutol	Methypylon
Sulfisoxazole	Paraldehyde
Flucytosine	Parglycine
	Primidone
	Trichlorethylene
<i>Antihypertensives</i>	Diphenylhydantoin
Diazoxide	Isocarboxazid
Methyldopa	Paracetamol
	Acetophenetidin
	Eucalyptus Oil
	B-Complex Vitamins
<i>Endogenous Toxins</i>	Bromide
Potassium	Magnesium
Sodium	Arsenic
Uric Acid	Fluoride
Calcium	Iodine
Water	Potassium Dichromate
Porphyris	Quinine
	Quinidine

We would like to acknowledge the assistance of Mary B. Pipkins in the preparation of this manuscript.

- Ingestion and probably absorption of a potentially lethal dose.
 - Blood levels in the fatal range.
 - When an underlying disease of the patient (e.g., cirrhosis of the liver) impairs the excretion of the particular drug.
 - Presence of a significant quantity of circulating toxin which is metabolized to a more noxious substance (e.g., methanol to formaldehyde; ethylene glycol to oxalic acid).
 - Progressive clinical deterioration under careful medical management.
 - Prolonged coma.
 - Presence of an underlying disease, such as obstructive pulmonary disease, which would increase the hazards of coma.
 - Development of a significant complication.
- Careful clinical evaluation, considering the above guidelines plus a knowledge of the ingested drug's metabolism, should allow one to make the correct decision.⁸⁻¹⁰

E. Other clinical problems where peritoneal dialysis has been used with more or less success are:

1. Intractable congestive heart failure, where large amounts of fluid can be removed safely over 24-36 hours without causing serious hypotension or cardiovascular complications. Restoration of diuretic responsiveness has been achieved in some cases.¹¹
2. Pulmonary edema following acute myocardial infarction.¹²
3. Generalized peritonitis in which this technique allows direct application of antibiotics to the disease area.^{13, 14}
4. In acute pancreatitis,¹⁵ peritoneal dialysis is sometimes helpful, for reasons not well understood.

Technical Aspects

A dialysis catheter has to be inserted in the peritoneal cavity for administration and removal of dialysis fluid. If the patient will require prolonged or repeated dialysis treatments, implantation of an indwelling silastic catheter, using the method described by Tenckhoff¹⁶ is a satisfactory approach to peritoneal access. This will avoid repeated abdominal punctures and carries a low risk of bacterial contamination.

More common is the use of a temporary silastic catheter, introduced blindly through the abdominal wall. The patient's bladder should be emptied and the abdominal wall cleansed appropriately. Using sterile technique, a small 1-2 mm incision is made in the skin at the site where the catheter will be placed

later. This should be in the mid-line, mid-way between the umbilicus and the symphysis pubis. If this approach is not possible due to infection or previous surgery at this site, a lateral insertion should be tried, mid-way between the umbilicus and the anterior iliac crest, 1-2 mm outside the anterior rectus muscle.

Before implanting the catheter, it has been found useful to infuse two liters of dialysate intraperitoneally to help avoid complications from catheter insertion. Some type of blunt needle should be used for this purpose.

Using one hand to steady the catheter perpendicular to the skin at the site of puncture, pressure is applied with the other hand to force the peritoneal catheter, with stylet inserted, through the abdominal fascia into the peritoneum. One should feel a cessation of resistance when the catheter breaks through the peritoneum into the abdominal cavity. At this point, to minimize such complications as perforation of a viscus, the stylet is withdrawn one centimeter inside the catheter sleeve and the catheter is directed into either pelvic gutter. After the catheter is in the gutter, the stylet is withdrawn, the pre-shaped catheter is then positioned in the gutter, and dialysis may be begun.

Physiologic Considerations

Optimal clearances of different solutes are probably obtained exchanging 3 to 3½ liters twice hourly.¹⁷ However, this volume of exchange is often difficult to obtain without automated equipment. For practical purposes, an effective program is one 2 liter exchange per hour as follows; the fluid is run in as fast as possible, allowed to equilibrate for 15-20 minutes, and then is drained for the remainder of the hour when the next cycle is started.

The clearance of different solutes varies, being maximal for urea. Two and one half liters per hour exchange will give a urea clearance of approximately 26 ml/min; potassium clearance of 21 ml/min; sulfate of 20 ml/min; phosphate of 16 ml/min; creatinine of 15 ml/min; uric acid of 14 ml/min; magnesium of 11 ml/min; and calcium of 9.5 ml/min.¹⁷

When the dialysate is made hypertonic by adding glucose, water is removed in excess of solutes; because glucose will be absorbed, it should not be allowed more than 20 minutes dwell time.

Efficiency of dialysis is improved by warming the dialysate to body temperature (37° C). This enhances urea clearance by 35 per cent, as compared with a dialysate temperature of 20° C.¹⁸ Efficiency may also improve after several hours of dialysis,

probably due to subclinical peritoneal irritation from the hypertonic solutions used.⁷

Addition of other substances to the dialysate may facilitate removal of certain compounds. For example, albumin may enhance clearance of substances that bind to protein (e.g., bilirubin, phenobarbital, and salicylates). Alkali, such as bicarbonate, may ionize weak acids, e.g., salicylates, and may also increase the solubility of uric acid. The absorption of bicarbonate from the dialysis fluid helps to neutralize acid radicals in metabolic acidosis. Minimal amounts of dioctyl sodium sulfosuccinate accelerates removal of urea and phosphate, but not of creatinine.¹⁹

Considerable work has been done concerning the composition of peritoneal dialysis fluid. There are two principal osmolar concentrations available at this time, depending on the amount of glucose present; 1.5 per cent dialysate contains 15 gm of glucose per liter, and has an osmolality of 372 MOSM/l. The 4.25 per cent dialysate contains 42.5 gm of glucose, and an osmolality of 525 MOSM/l. Both solutions are hypertonic to plasma and a negative water balance can be achieved with either one (up to 6 l/24 hrs with the weaker solution and 8-12 l/24 hrs if the 4.25 per cent fluid is used).²⁰ More hypertonic solutions were removed from the market because of the high incidence of hyperosmolar reactions.

The dialysate mixture is potassium free, so this ion will be rapidly removed from the body due to the gradient created between blood and peritoneal fluid. If removal of potassium is not needed, it should be added to the dialysate in appropriate quantities to overcome that gradient (4 mEq/l).

Complications

1. Peritonitis remains the most common complication of peritoneal dialysis. New techniques, such as the use of the Tenckhoff catheters and automated closed systems, have reduced the incidence of peritonitis to 0.4-0.7 per cent without prophylactic antibiotics.⁷ The rate of infection increases up to 2.1 per cent with use of commercial dialysates and the non-automated open system.^{3, 4} If dialysis time is longer than 48 hours, we have found that incidence of peritonitis becomes considerably greater.

The signs of peritonitis are abdominal pain and tenderness, cloudiness of the dialysate drainage, fever, and leukocytosis. Gram negative or staphylococcal organisms have been the most common offenders. The best approach to the problem is not to discontinue dialysis, but to add appropriate antibiotics to the dialysate in amounts enough to reach the minimum inhibitory concentration in 2000 cc of fluid.

The antibiotics chosen depend on the organisms seen on the gram stain of centrifuged dialysate, and coverage would be changed depending on the results of cultures. Systemic antibiotics are rarely necessary unless the patient becomes toxic.

2. Abdominal pain and discomfort are rather common complaints and may be due to several causes. If the fluid is warmed excessively, peritoneal irritation may occur. In patients with rigid or poorly distensible abdominal walls, discomfort may force the use of smaller volumes at the beginning of dialysis. Mechanical irritation of the peritoneum, omentum, or other structures may occur; repositioning of the catheter usually solves the problem.

3. Pulmonary complications have not been common in our experience but some series report such complications in up to 37 per cent.²¹ These may include atelectasis due to upward displacement of the diaphragm, pneumonia, effusions, and rarely hydrothorax due to pre-existing diaphragmatic defects. Those problems can be avoided by decreasing retention time and volume of fluid in patients prone to develop those complications such as small patients or those with rigid, muscular abdominal walls.

4. Protein depletion is rare. Even though large quantities of protein are removed during dialysis, albumin levels below 3.0 gm per cent are unusual, provided that those patients are maintained on no restriction of high quality protein diet during dialysis. Liver synthesis of albumin appears to be adequate to compensate for the loss.

Tenckhoff found losses of protein in the dialysate of 11-47 gm (mean 24 gm) per 12-14 hours of peritoneal dialysis.⁶ These protein losses increase considerably during an episode of peritonitis. Bianchi et al²² analyzed mechanisms of albumin loss during peritoneal dialysis, and reported that albumin loss was higher in the first 3-4 dialysates, becoming more nearly constant in later samples. They believe that most of the protein is lost by exchanging with dialysate remaining in the abdominal cavity from the preceding dialysis, and that loss of protein occurs in three ways:

- A. Albumin shift from extravascular sites adjacent to peritoneum.
- B. Direct passage of albumin from the blood stream to peritoneal cavity.
- C. Tendency of inter-dialysis fluid to equilibrate with plasma protein levels.

5. Disequilibrium syndrome occurs considerably less often than in hemodialysis,²³ because the shift of solutes and fluids is less rapid. This syndrome is

thought to be due to rapid decrease in osmotically active particles by dialysis, that can not be paralleled by the brain, because of the influence of the blood brain barrier. This seems to produce an osmotic gradient between blood and brain, causing movement of water into the brain, and resulting in encephalopathy, cerebral edema and increased intracranial pressure. Rapid correction of systemic acidosis leaving an acidic CNS may also predispose to disequilibrium reactions, manifested by delirium, convulsions, headaches, nausea, muscle cramps, etc. at the end of or soon after dialysis.

6. Metabolic alkalosis may occur as a consequence of "over-treatment," but usually carries no serious clinical implications.

7. Complications of catheter insertions such as perforation of a viscus or blood vessel, can be reduced by filling the abdomen with fluid before catheter insertion.

As some air will be introduced in the peritoneal cavity, the otherwise helpful sign to diagnose a perforated viscus of free air under diaphragm is of no value in those cases.

Difficulty in retrieving fluid after an apparent free catheter insertion may be due to:

- Leakage of fluid extraperitoneally.
- Exceptionally rapid fluid absorption from the peritoneum.
- Air leak that breaks the siphon effect.
- Occlusion of the catheter by omentum.
- Blockage of the catheter by fibrin clots or tissue debris.

We routinely add 500 units of heparin to every other dialysis run to avoid some of this blockage.

Repositioning or reinsertion of the catheter may sometimes be necessary to solve the above mentioned difficulties.

Contraindications

If hemodialysis is unavailable, there are no contraindications to peritoneal dialysis, and this potentially life-saving mode of treatment should not be withheld.

Relative contraindications to peritoneal dialysis are the following:

1. Lack of adequate nursing care.
2. Abdominal drains or colostomy.
3. Undiagnosed abdominal disease.
4. Extensive interperitoneal adhesions, or prior multiple abdominal surgical procedures.
5. Recent abdominal surgery with use of prosthetic material, e.g., Dacron arterial grafts.

(Continued on page 124)

Current Trends in the Management of Acute Hemorrhagic or Necrotizing Pancreatitis

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THE TREATMENT OF acute edematous pancreatitis has traditionally incorporated intravenous fluids, gastroenteric rest, and broad spectrum antibiotics in a setting which provides close monitoring of parameters of resuscitation and acid base balance. It is undertaken in this discussion to review those fundamental precepts of care and to outline the newer and sometimes controversial aspects in the treatment of hemorrhagic or necrotizing pancreatitis. Attention in this direction is warranted by the severity of acute hemorrhagic or necrotizing pancreatitis. In a recent review of cases of uncomplicated acute edematous pancreatitis at the University Medical Center, there was an 11.2 per cent mortality. In collected series of necrotizing pancreatitis, there has been noted 70-100 per cent mortality. Here at the University Medical Center, necrotizing pancreatitis has resulted in a 72.9 per cent mortality when averaged over the past 20 years.

The standard medical regimen on the surgical service has included gastroenteric rest: nasogastric suction for decompression, discontinuation of all oral intake, and attention to restoration of electrolyte abnormalities. Massive intravenous fluid replacement may be required. The parameters most commonly monitored for assessment of adequate resuscitation and fluid replacement are cardiac output as manifested by peripheral perfusion and urine output, and central venous pressure as a reflection of the ability of the heart to handle its fluid load. Acid base balance and electrolyte restoration are determined by appropriate laboratory studies. In the following discussion, the elements of aggressive non-surgical management and timely well-planned surgical intervention are outlined.

Etiologic Factors

Most commonly indicted as a cause of acute edematous pancreatitis is biliary tract stones. In the

city-county hospital or setting of low income patients, the most frequent etiologic factor is alcohol ingestion. Both blunt and penetrating abdominal

Aggressive medical and surgical therapy is advocated by the authors in cases of hemorrhagic or necrotizing pancreatitis. A discussion of the fundamental precepts of therapeutic management with reappraisal of treatment modalities is presented, as well as a review of the recent medical literature. Emphasis is placed on early and correct diagnosis, the elements of aggressive non-surgical management and timely well-planned surgery.

trauma are not uncommon causes of pancreatitis. Metabolic causes are both hereditary and acquired; cystic fibrosis, hyperparathyroidism, pregnancy, and hyperlipemia represent a few. The general category of vascular causes may include a broad spectrum of etiologies from inflammatory vascular disease to varieties of localized thrombosis or connective tissue disorders. Infection, both systemic and localized, has been indicted as an etiologic factor in pancreatitis. Some drugs, including steroids, antibiotics, thiazides, and oral contraceptives, have been shown to play a role in the etiology of pancreatitis.

Pathophysiology

Necrotizing pancreatitis is thought by many to begin as edematous pancreatitis. The liberation of proteolytic and lipolytic enzymes into the interlobular spaces of the pancreas alters capillary permeability and causes loss of volume from the generalized circulation. Consequent vasoconstriction reduces inflow to the pancreas; decreased outflow from the pancreas via the lymphatic and portal systems predisposes to venous and arteriolar thrombosis. Subsequent focal or generalized pancreatic necrosis may then be accompanied by hemorrhage. An incidence

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of 25 per cent has been noted for hemorrhage in cases of necrotizing pancreatitis in recent series.¹

Signs and Symptoms

Early signs and symptoms of necrotizing or hemorrhagic pancreatitis are those of acute edematous pancreatitis (see Table I). Upper abdominal pain radiating to the flanks and back is the most common finding. Nausea and vomiting and anorexia soon follow; ileus may be manifested by abdominal distention as well. Tachycardia reflects fluid volume losses and the hyperdynamic state. Fever is an inconstant finding.

TABLE I
SYMPTOMS AND SIGNS OF
ACUTE HEMORRHAGIC PANCREATITIS

Upper Epigastric Pain Radiating to Flanks
Nausea and Vomiting
Adynamic Ileus
GI Bleeding
Early Respiratory Insufficiency
Renal Insufficiency
Gray Turner's Sign
Cullen's Sign
Subcutaneous Fat Necrosis
Shock
Tachycardia Out of Proportion to Temperature Elevation
Bloody Ascites
Deterioration of Patient on Standard Medical Regimen
Failure to Improve with Standard Treatment for Pancreatitis

Later findings include cardiovascular instability and prostration. Gastrointestinal bleeding may occur as a result of bleeding into the pancreatic ductal system in instances of hemorrhagic pancreatitis. Respiratory insufficiency may be reflected by signs and symptoms of hypoxemia. Early development of respiratory insufficiency may forbode a more severe episode of pancreatitis. In one series, over 80 per cent of patients had no clinical or x-ray evidence of pulmonary problems even in the face of severe hypoxemia.² Atelectasis or pleural effusion are not uncommon sequelae. Pulmonary injury may be due to loss of integrity of the alveolocapillary membrane as a result of circulating free fatty acids, phospholipase A, and vasoactive substances. Abdominal pain, distention, and pleural effusion may cause decreased diaphragmatic excursion and inadequate lung expansion. Treatment of such pulmonary insult is usually directed toward reestablishment of appropriate ventilatory capabilities and oxygenation. En-

TABLE II
LABORATORY FINDINGS

Elevation of Serum or Urinary Amylase
Serum or Urinary Lipase Elevation
Decline in Hematocrit Level
Hypocalcemia
Arterial Po ₂ Less than 60 mm Hg
Marked Increase in Indirect Bilirubin Due to Retroperitoneal Hemorrhage
Methemalbumin in Serum, Ascites, Pleural Fluid
Leukocytosis
LDH and SGOT Elevation

dotracheal intubation and positive end expiratory pressure (PEEP) respiration may be required.

Renal insufficiency may result from massive loss of fluid with inadequate replacement. In a series of almost 500 patients with pancreatitis, 83 per cent of those with azotemia did not survive.³ Early fluid and electrolyte loss with concomitant acidosis and decreased renal perfusion is augmented by the direct effect of pancreatic enzymes and vasoactive polypeptides in the kidney. The only effective treatment in the face of appropriate resuscitation by other standards may be hemodialysis.

Incidental and ominous prognostic signs include ecchymosis of the flanks (Gray-Turner's Sign), ecchymosis of the periumbilical area (Cullen's Sign), or areas of subcutaneous fat necrosis.

The most constant laboratory finding is an increased serum amylase and serum lipase. An increased urinary amylase may be a reliable diagnostic finding in the absence of elevated serum amylase. Fractionated specimens are most reliable, and several two-hour urinary specimens should be collected. Excretion in excess of 300 units per hour is considered diagnostic of pancreatitis. A patient may have a normal 24 hour urinary amylase excretion with elevation of fractionated collection increments in the presence of acute pancreatitis. Hemoconcentration is reflected by increased hematocrit. Hypocalcemia results from controversial metabolic changes. In the past hypocalcemia and hypomagnesemia were thought to be the result of saponification of fat and sequestration of calcium and magnesium in soaps. However, abnormalities of parathormone and calcitonin have recently been described and investigated. Evidence is inconclusive as to the exact hormonal etiology, but by and large the lower the serum calcium level the more ominous the prognosis. Acidosis results from retroperitoneal inflammatory changes and from poor distal perfusion secondary to hypovolemia. Arterial blood gases will likewise

reflect arterial oxygen desaturation. Increased white blood cell count is accompanied by an increase in hepatic and muscle enzymes, specifically LDH, SGOT, and bilirubin.

Methemalbumin has been detected in serum, ascites, and pleural fluid. This is not pathognomic of hemorrhagic pancreatitis but is consistent with a high rate of intravascular hemolysis or bleeding into the tissues exceeding the capacity of haptoglobin binding. This laboratory finding may also be present with dead bowel, ruptured aneurysm, or mesenteric occlusion.⁴⁻⁶

Radiologic Findings

Classic findings of pancreatitis may be present to a variable extent on x-ray. Most commonly the abdominal film will reveal obliteration of psoas shadows because of retroperitoneal edema. Increased bowel gas may reflect the presence of ileus. The sentinel loop is a dilated loop of small bowel which overlies the pancreas, representing localized ileus. The colon cutoff sign is likewise the result of segmental ileus and shows a sharply demarcated termination of colon gas in the transverse colon near the area of the splenic flexure. Pancreatic calcification may be evident in subacute and chronic cases. Chest x-ray may reveal focal atelectasis, elevated hemidiaphragm, pleural effusion, or frank infiltrate. Contrast studies such as upper GI may demonstrate a widened C-loop, and perhaps anterior or lateral displacement of the stomach by the inflammatory pancreatic mass.

Pancreaticoduodenography has been generally discouraged in acute episodes of hemorrhagic or necrotizing pancreatitis. A recent proponent, Dr. Williams of Boston, has modified his previous stand for use of pancreaticoduodenography in acute episodes of edematous pancreatitis, and now recommends its use only after the patient has been nutritionally replaced and is ready for imminent surgery.⁷

Differential Diagnosis

In consideration of all previously delineated symptoms and signs, several acute abdominal entities come immediately to mind in establishing a differential diagnosis. Representative disease entities which may present with one or numerous of the signs and symptoms of acute hemorrhagic pancreatitis are listed in Table III. A noteworthy number of patients initially thought to have acute pancreatitis actually have a different potentially fatal condition requiring operative management. Such an experience makes detailed and repetitive reevaluation of pa-

TABLE III
ETIOLOGIC FACTORS

Biliary Tract Disease
Alcohol Ingestion
Trauma
Cystic Fibrosis
Infection
Vascular Occlusion
Hyperparathyroidism
Pregnancy
Hyperlipidemia
Drugs
Familial (rare)

tients being treated for hemorrhagic or necrotizing pancreatitis a strict obligation.

Medical Treatment

Adequate medical treatment early in the course of an attack of acute edematous pancreatitis may prevent many cases from progressing to necrotizing pancreatitis. Experience with new parameters of medical therapy will hopefully play a significant role in the future in short-circuiting the progression of edematous to necrotizing pancreatitis. Standard resuscitation and support must be accompanied by close monitoring. Massive volumes of intravenous crystalloid solution may be required in restoring appropriate fluid and electrolyte balance. Parameters for adequate resuscitation include such findings as clear sensorium, good urine output, decreased tachycardia to less than 100, etc. Replenishment of calcium and magnesium should be included. Gastrointestinal rest is carried out by placing the patient NPO: a nasogastric tube is used to decompress the upper intestinal tract. Antacids are used for prophylaxis in this instance of stress, and also to decrease pancreatic secretory stimuli. Anticholinergics play a controversial role. Those in favor of their use feel that the exocrine secretions of the pancreas are decreased in the acute episode of inflammation. Avoidance of morphine has been proposed in the attainment of pain relief. Morphine is known to be a strong stimulant to sphincter of Oddi spasm. Though demerol has been indicted for causing the same effect, it has been more popularly used. Non-narcotic synthetic analgesics can be an alternative to either of these opiates.

Respiratory support should include administration of oxygen and appropriately aggressive pulmonary toilet. Mechanical ventilatory support may become necessary, and positive end expiratory pressure is applied when necessary.

PANCREATITIS / Cook and Selby

The use of peritoneal dialysis in the treatment of necrotizing and hemorrhagic pancreatitis has experienced a recent resurgence of interest. There is convincing experimental and clinical evidence for dramatic improvement in those patients deteriorating on medical treatment.⁸⁻¹⁰ Removal of vasoactive polypeptides and proteolytic and lipolytic enzymes has been promulgated as the beneficial effect of dialysis.¹¹ The authors feel that peritoneal dialysis has been used too infrequently. Present evidence suggests that earlier consideration may ameliorate the clinical course. Evidence for less fluid sequestration and maintenance of a normal serum calcium has been shown. Earlier cardiovascular stability is established, and a decreased serum amylase may be seen. The experience of Ranson in 1973 and 1975^{2, 12} and most recently as described in *Surgery, Gynecology and Obstetrics* in 1976¹³ compares the value of surgical and aggressive nonsurgical treatment of pancreatitis. By 1975 Ranson had evaluated 300 cases of pancreatitis, 100 of which were evaluated in a retrospective fashion; the remaining 200 were randomized prospectively. By careful analysis of these cases Ranson has established a series of grave prognostic signs¹³ (see Table IV). Firm evidence for the superiority of aggressive non-operative therapy now exists.

A number of controversial or unproven adjunctive therapy modalities are worthy of mention. Trasylol, which is a proteolytic enzyme inhibitor, has been used broadly in Great Britain and the remainder of Europe. It is presently not approved for use in the U. S. clinically, and studies here have shown it to be effective only if used in high doses at the time of induction of pancreatitis experimentally.¹⁴ Recent reports from Europe are more encouraging by manipulation of chemical characteristics, doses, and treatment intervals.¹⁵ Anticoagulants play the theoretic role of maintaining pancreatic blood flow. Heparin or fibrinolysin have been shown to be effective only if used immediately after onset of pancreatitis. Low molecular weight dextran, on the other hand, is effective even 12 hours after the onset of experimental pancreatitis.¹⁶ Vasopressin has likewise been demonstrated to maintain blood flow and perfusion of the pancreatic microcirculation. It, too, requires almost immediate use and is presently of questionable clinical value.

Elemental diets have been encouraged in incidences of prolonged or complicated acute and subacute pancreatitis. In those patients whose gas-

trointestinal tract will tolerate it, appropriately administered elemental diet will establish a positive nitrogen balance and may contribute significantly to recovery. Decreased volume and acidity of gastric juice have been demonstrated. Decreased volume of pancreatic secretion and decreased proteolytic enzyme production likewise follows administration of elemental diets.¹⁷

TABLE IV
RANSON'S ELEVEN GRAVE
PROGNOSTIC SIGNS*

On Admission
Age over 55
WBC greater than 16,000
Blood glucose greater than 200 mg %
LDH greater than 350 IU/l
SGOT greater than 250 Sigma Frandel Units %
During Initial 48 Hrs.
Hct decrease over 10% points
BUN rise over 5 mg %
Ca++ level below 8 mg %
Arterial Po ₂ below 60 mm Hg
Base deficit over 4 meq/liter
Estimated fluid sequestration over 6 liters

* SG&O 143:209, Aug. 1976.

In cases of experimental pancreatitis, 5 fluorouracil has been administered and mortality was noted to be decreased from 90 per cent to 0 if 5-Fu is begun simultaneously with the onset of disease. There is a proposed interference with protein synthesis which decreases production and release of proteolytic enzymes.¹⁸

Steroids have been utilized in hemorrhagic and necrotizing pancreatitis as in most other disease entities. They have been found, however, to be beneficial only if given within one hour of onset of experimental pancreatitis.¹⁹

The use of antibiotics is a widely debated and controversial aspect of nonsurgical treatment of pancreatitis. Prejudice of surgeons is obvious because infectious complications of medical pancreatitis become surgical problems. For this reason there is a skewed exposure. There is, however, an absence of experimental evidence favoring their use prophylactically; in recent clinical studies there is a suggestion of no value in prospective evaluation.²⁰ Sporadic reports may be used to support either side of the argument at present. The number of variables almost precludes a definitive statement as to the value of prophylactic antibiotics. However, we favor the early use of broad spectrum antibiotics because of low morbidity in a presently equivocal situation.

Indications for Surgery

Indications for surgical treatment or intervention in the treatment of hemorrhagic and necrotizing pancreatitis have been well delineated. Doubtful or uncertain diagnosis with regard to specificity always leaves the surgeon hovering on the brink of operative intervention. Deterioration in the face of aggressive nonoperative therapy has been an indication in the hope that wide local debridement or drainage and the possibility of finding an obscure but reversible etiologic factor is certainly an indication for surgery. Signs or symptoms suggestive of precipitating circumstances or complications amenable to surgical therapy which occur at any time in the course of nonsurgical therapy of pancreatitis should prompt surgical intervention. Previous history of untreated cholelithiasis is unequivocally an indication for early operative intervention. Gallstone pancreatitis is highly lethal. Although decompression of the biliary tract and bypass of the upper gastrointestinal and pancreatic area is the treatment of choice, cholangiography with common duct exploration has on occasion been necessary. Frey reported success with a majority of his patients undergoing cholecystostomy and/or common bile duct decompression in alleviating recurrent attacks of pancreatitis.²¹ In the instance of acute alcoholic pancreatitis, surgery is directed at the complications such as abscess or pseudocyst formation, rather than at factors which initiate or perpetuate the disease. Cholecystectomy or biliary surgery is ill-advised if chronic alcoholic ingestion is the suspected diagnosis.

Surgical Modalities

Surgical drainage of the retroperitoneum through the flanks or through the bed of the twelfth rib has been felt to prevent the accumulation and sequestration of fluid in the inflamed retroperitoneal space. Egress of necrotic pancreatic material is allowed in this fashion; and control and detection of fistula formation are said to be facilitated. Resection of necrotic debris and nonviable pancreas at the time of surgery has been felt to reduce late abscess formation. Hemodynamic recovery has been said to be almost immediate upon removal of the source of vasoactive polypeptides and proteolytic enzymes. A broad spectrum of resection had been promulgated as treatment of choice, from 95 per cent Child's type resection to simple amputation of the tail. Both the Du Val procedure and pancreaticoduodenectomy have at some time been proposed in the appropriate treatment of hemorrhagic pancreatitis. Present stud-

ies, lacking good objective comparative data, make evaluation of these highly morbid procedures a difficult and treacherous undertaking.

Several investigators have been proponents of drainage procedures. Jordan and associates had a 57 per cent mortality rate in patients treated with drainage. Sixteen of his patients who were treated medically without dialysis had a 100 per cent mortality rate.²² Waterman reported a low 10 per cent mortality rate in 10 patients treated with early laparotomy and sump drainage of the retroperitoneum alone.²³

Wide retroperitoneal drainage accompanying gastrostomy, cholecystostomy, and jejunostomy (the so-called "triple tubing") has widespread support as operative therapy. Lawson and associates at Massachusetts General Hospital reported a 26 per cent mortality rate in a group of 15 patients who were treated in such a fashion for progressive necrotizing pancreatitis. All patients who died were noted to have been operated on more than 72 hours after onset of symptoms and were associated with a septic retroperitoneal mass.²⁴ In the British experience with operative intervention, Trapnell showed no difference in morbidity or mortality between non-operative and operative groups in 324 cases of acute pancreatitis, 91 of whom underwent exploratory laparotomy. He noted that addition of definitive procedures outside of a direct attack on the pancreas did not increase morbidity or mortality.²⁵

Hollender of France is a proponent of resection. He reports a 35 per cent mortality in patients treated with partial pancreatectomy.²⁶ It is noteworthy that such a resection was most easily performed technically between 24 and 48 hours following onset of symptoms. Hermann and his associates in Cleveland resect only obvious necrotic material at the initial operation. Any apparent pancreatic duct obstruction is corrected, and they base the decision for pancreatic resection versus pancreatic duct drainage procedure on an operative pancreatogram and on degree of thickness, fibrosis, and calcification of the gland.²⁷

Eiseman and Norton of Denver have recently reported their experience with pancreatectomy for severe pancreatitis. A 65-85 per cent distal pancreatectomy was performed on four patients who were near death; three survived. They reported that the resection was surprisingly easy and that one pancreatic stump was not closed but merely drained without complication. Only one patient developed diabetes.

Summary

Though necrotizing and hemorrhagic pancreatitis are uncommon, a notably high mortality is reported. Appropriate treatment must be aggressive and well directed, whether medical or surgical. (Immediate institution of adequate and appropriate medical therapy may well intercede in the progression of simple acute edematous pancreatitis to hemorrhagic or necrotizing pancreatitis.) While dialysis is shown to be an effective means of treatment, early laparotomy should not be withheld if deterioration occurs in the face of an uncertain diagnosis. Laparotomy should be undertaken early in those patients who show deterioration or in those who show no improvement after 12 to 36 hours of aggressive non-surgical management. Documented calculous biliary tract disease is an undisputed indication for early decompression of the biliary tract. Appropriateness of further surgical intervention in the form of decompression, drainage, or resection is debated. It is felt that resectional debridement of necrotic pancreatic tissue should be performed, and that gastrointestinal and pancreatic rest be assured by the "triple tubing" technique. Sump drainage may be instituted and appropriate catheters placed for post-operative peritoneal dialysis. By present experience, resection seems to be indicated when biliary and gastric diversion, lavage therapy, and retroperitoneal drainage do not alter the progressive downhill course of hemorrhagic or necrotizing pancreatitis.

Occurrence of resuscitation and survival from aggressive nonsurgical treatment or from surgical management should not alleviate continued diligence necessary to recognize early and handle appropriately such late complications as fistula, abscess, or pseudocyst. Only through an aggressive cooperative effort directed at medical and surgical modalities of diagnosis, resuscitation, and therapy can mortality from hemorrhagic or necrotizing pancreatitis be reduced.

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Peritoneal Dialysis

(Continued from page 118)

6. Very recent abdominal surgery, with wound closure not yet achieved.

7. Infection at all possible sites of catheter insertion.

8. Bleeding diathesis (though peritoneal dialysis would probably be preferable to hemodialysis in this situation).

Acute peritoneal dialysis is a very useful mode of therapy. It is well tolerated by the patient and has a remarkably low incidence of complications. It is the procedure of choice in many cases necessitating acute dialysis. ★★★

For a complete list of references and reprint requests, write to Dr. Ruvinsky, Suite 425, 971 Lakeland Drive (39216)

Radiologic Seminar CLXX: Extraluminal Gas Collection in the Pelvis Due to Diverticulitis

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EXTRALUMINAL intra-abdominal or retroperitoneal gas collections usually indicate significant pathology, and prompt evaluation is imperative. The following case report demonstrates an unusual collection of gas in the pelvis due to a relatively common disease, diverticulitis.

Case Report

A 77-year-old well nourished, well developed male was admitted to the hospital in acute distress. He had complained for several days of indigestion, cramping and discomfort in the lower abdomen. There was a tendency toward constipation with only temporary laxative relief. There was no history of chills or fever. His admission temperature was 98.6. The abdomen was distended with marked tenderness across the entire lower abdomen. There was a questionable mass in the suprapubic area. On rectal examination there was slight enlargement of the prostate.

The patient was referred to the Radiology Department for a barium enema. A preliminary recumbent radiograph of the abdomen revealed a moderate amount of gas in both the small and large bowel without evidence of dilatation. The pelvic soft tissues were abnormal with evidence of extraluminal gas, more prominent on the right, extending inferiorly (see Figure 1). These findings suggested perforated intrapelvic bowel and the barium enema was cancelled.

At surgery there was a perforated distal sigmoid colon diverticulum near the pelvic floor with evidence of retro- and intraperitoneal contamination.

Discussion

Extraluminal gas collections seen on abdominal radiographs usually indicate perforation of a hollow gastrointestinal viscus or infection (abscess), with gas forming bacteria (i.e. *E. coli*, *Clostridium welchii*,



Figure 1. Plain radiograph of the pelvis. Note the multiple small circular and linear lucencies which project over the right side of the pelvis and extend inferiorly indicating extraluminal gas collections.

anaerobic Streptococci). In the past, diverticulitis was thought to develop following spasm or swelling of the diverticular neck with retention of feces in the diverticulum which subsequently became inflamed leading to abscess formation or perforation. The current concept is that diverticulitis begins as a micro-perforation of a distended diverticulum. This allows local spillage of colonic gas and bowel contents which if sufficient results in peridiverticular inflammatory abscess. Thus, what is called diverticulitis is actually a peridiverticulitis. The abnormal gas demonstrated in Figure 1 is likely a combination of colonic gas leaking through the diverticular perforation and gas produced by bacteria in a peridiverticular abscess.

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Hardy Wilson Memorial Hospital (39083)

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Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Hardy Wilson Memorial Hospital, Hazlehurst, MS.



The President Speaking

An Eventful Time

LYNE S. GAMBLE, M.D.
Greenville, Mississippi

OUR ANNUAL SESSION was held last year during the time that the Sub-Area Council elections for the Health Systems Agency were being conducted. In accordance with a directive of the House of Delegates, an official protest relative to the manner in which these elections were being conducted was submitted to H.E.W. We feel that many of the conditions imposed were a result of the protest made by our association.

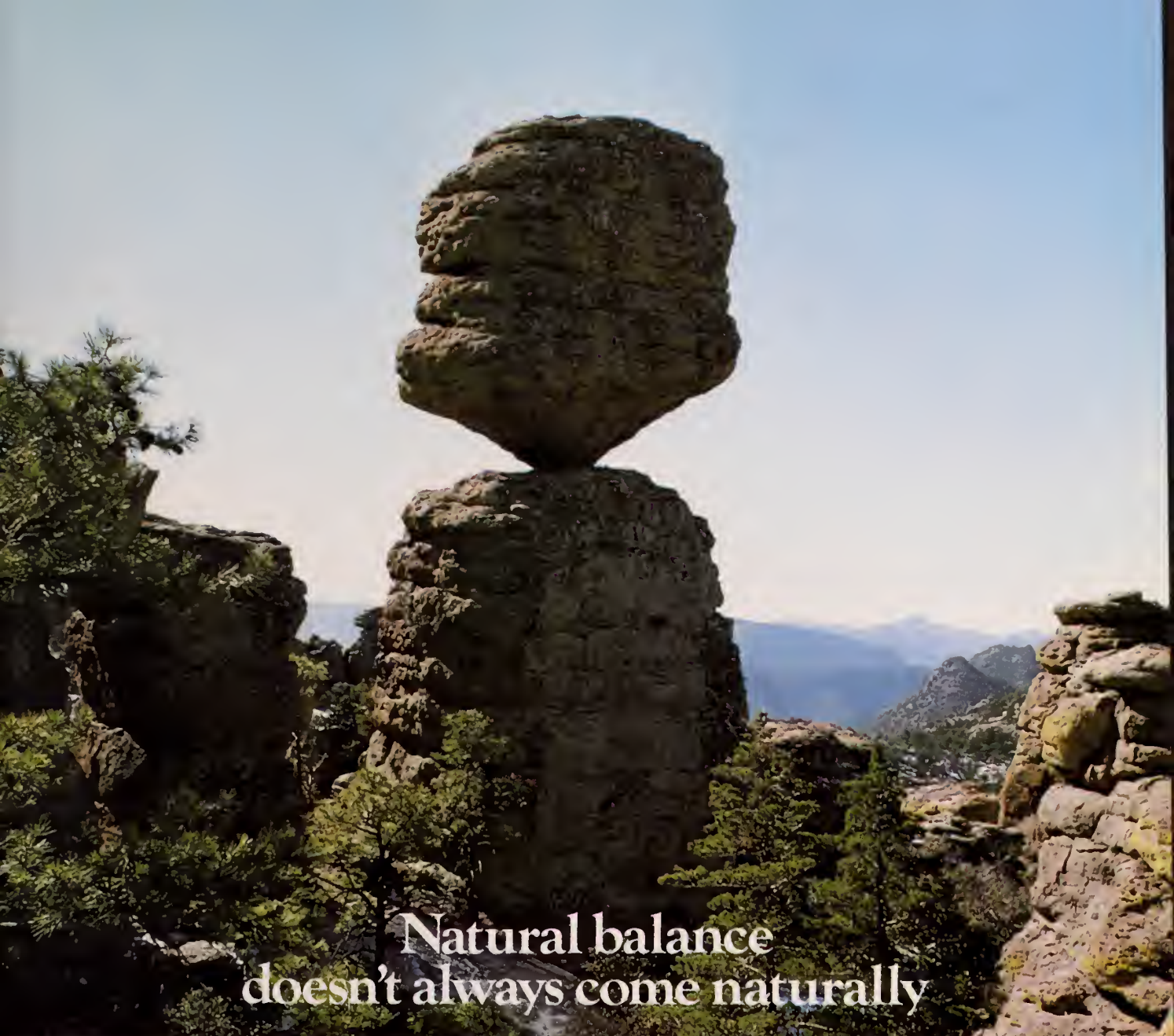
The suit which was authorized by the House of Delegates in 1975 to "Terminate apparent practices of chiropractors in the state which violate the provisions of the Chiropractic Licensing Act and result in the practice of medicine without a license" was tried in the Chancery Court, First Judicial District, Hinds County, Mississippi. The trial began on June 15 and was adjourned on June 21 for the summer. The trial began again on September 7 and ended on September the 10th. The opinion of the Chancellor was rendered on March 8, 1977. The defendant was permanently enjoined from using those practices to which the Mississippi State Medical Association had objected. This action is now being appealed to the Mississippi State Supreme Court.

In the Legislature, after five years, the association's proposals to grant immunity from liability to members of peer review committees and individuals or organizations who furnish information to such committees has been passed by both houses and has been signed by the governor. SB 2031 which deals with medical discipline has been passed by both houses and has been signed by the governor. HB 1144, the measure which would grant statutory authority for the Mississippi Fraternal and Educational Society, has been passed by both houses and has been reported by a joint House-Senate conference committee.

The bill which would have authorized optometrists to diagnose and utilize medications died on the calendar of the House. The Mississippi State Medical Association is opposed to the diagnosis of disease and the use of medication by any non-medically trained person. The optometry problem is but a part of a much larger and much more profound threat to medical care as rendered by the whole medical profession.

The legislation which established the Mississippi State Board of Health in 1926 provided that, "eight of the appointive members shall be regular qualified physicians of this state and members of the state medical association. They shall be nominated to the governor by the state medical association, three from each congressional district in the state, from which number the governor shall appoint one." It is my opinion that one of the purposes of this legislation was to minimize or eliminate political consider-

(Continued on page 128)



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

- **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.
- **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.
- **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

***INDICATIONS.** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg/kg/day in rabbits and 10 mg/kg/day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.


Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert[®]/25 
(meclizine HCl) 25 mg. Tablets
for vertigo*

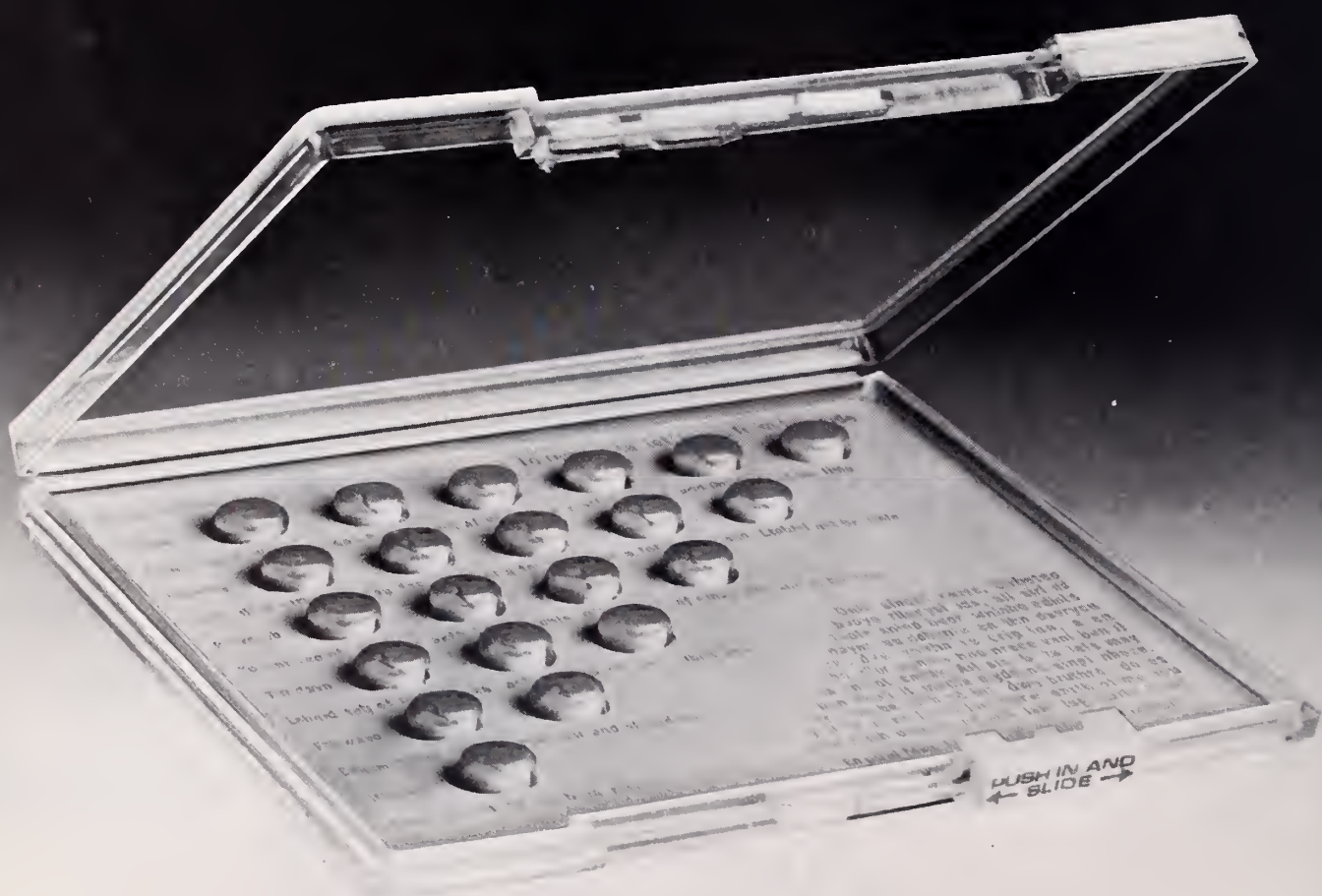
Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

Medrol[®] 4 mg Dosepak^{*}

methyprednisolone, Upjohn

The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.



EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XVIII, NUMBER 5

MAY 1977

The Silent Majority

This country was founded on the premise of majority rule. Laws and regulations were made not to preserve individual rights but to also benefit the greatest number of people. For the past several years, the trend seems to be toward compromise of these ideals in favor of minority groups.

Most of us believe in individual liberty, environmental protection and conservation of natural resources, but we also believe that some adjustment of attitude is often necessary for the common good of the majority.

While the Silent Majority sits in the coffee room griping to his colleagues, the dissident minority holds sit-ins, protest marches, and strikes, while violently waving placards before the T.V. camera. Multimillion dollar water resource projects which would benefit thousands of Americans are held up by environmentalists who fear the drowning of a few endangered polywogs.

We refer to "We" as the people and "They" as the federal government. Surely, we must realize that "We" elect the congressmen who are pledged to pass laws consistent with majority rule, but once elected, we sit silently by, too lazy to even write a letter to our congressman. Meanwhile, minority pressure groups influence the thinking of our senators, representatives, and judges.

The time has come for the Silent Majority to become more vocal and insist on laws which benefit the most people.

GEORGE H. MARTIN, M.D.
Associate Editor
Vicksburg, MS

Medicare "Fraud and Abuse"

The Department of H.E.W. which has recently coined and overworked the phrase "fraud and abuse" committed some abuse if not downright fraud itself with release of information about providers

paid in excess of \$100,000 by Medicare in 1975.

Of 112 physicians on the list checked by the AMA, only 32 were correct as listed leading AMA Executive Vice President, Dr. James H. Sammons, to term the list "incredibly erroneous" and as showing "great irresponsibility on the part of a major segment of government."

In Mississippi a spot check by MSMA staff of physicians listed showed a 50 per cent error rate and this has been officially brought to the attention of the state's Congressional Delegation.

As the errors piled up, H.E.W. said it was conducting its own investigation and in typical bureaucratic fashion attributed the mistakes to its fiscal intermediaries and the Associated Press. This led the *Chicago Daily News* to editorially state "H.E.W., in whose name the information was issued, bears the ultimate responsibility, and the publication of such gross inaccuracies as the Medicare list apparently contains indicates slovenly and reprehensible record keeping at the federal agency, serving neither the cause of medical care for the aged nor the public's right to know where its tax dollars are being spent."

We suggest you put that on your salad bar, Mr. Califano!

CHARLES L. MATHEWS
Executive Secretary

A New Face for the Journal

This month the JOURNAL MSMA "takes on a new face" replacing the cover it has "worn" since its inception in January of 1960.

The new cover features an enlarged drawing of the MSMA caduceus. Artist is Mary Jane Whitfield of Jackson, who holds the Master of Art degree and teaches art at Pearl High School. She is the daughter of Dr. and Mrs. Edmond L. Whitfield of Florence.

Eli Lilly and Company, the ethical pharmaceutical manufacturer which has purchased the cover ad for 17 years, has graciously agreed to buy advertising

EDITORIALS / Continued

within the journal, thus continuing the firm's support of the association and the JOURNAL MSMA.

Other minor changes took place within the covers. Headlines are now a more modern boldface type and are flush left instead of flush right.

The Committee of Publications, which oversees publication and production of the journal, approved all changes at the February 1977 meeting. For the most part, the clean format and traditional style will remain the same as the committee believes the journal to be a professional appearing and aesthetically pleasing publication. Comments from the membership will be welcomed.—NG

The President Speaking

(Continued from page 126)

ations in making these appointments, and to assure the selection of medical leaders respected by their peers to administer this state's public health needs. The Mississippi State Medical Association has complied with the law. It is the contention of the governor that this law is unconstitutional and the Mississippi State Medical Association has been named as a defendant in a court action, United States District Court, Southern District of Mississippi. A hearing on our motion to dismiss this suit has been scheduled for April 27, 1977, in Biloxi. In addition to being the licensing agency for physicians, the State Board of Health is charged by statute to narcotic problems among physicians. Several years ago, the so-called "sick doctor" act was passed. This measure deals with the mentally or physically disabled physician. The State Board of Health is instrumental in its enforcement. The State Board of Health would likewise be instrumental in the enforcement of the recently passed S.B. 2031 which would authorize disciplinary proceedings against a physician for professional incompetency. It is imperative that we exert every effort to prevent any situation which would make possible the political manipulation of this Board.

I found the meetings of the AMA to be impressive and instructive. However, in spite of prolonged deliberations, a majority of the House of Delegates could not see what is so obvious to all of us. Namely, that Medicare reimbursement policies are fundamental factors in the maldistribution of physicians.

The support of the membership, the cordiality of component society meetings, the pleasure of working with dedicated members of our councils and com-

mittees, a loyal, untiring and judicious Board of Trustees, and a skilled, efficient and cheerful staff more than compensate for some of the arduous and troublesome problems that have been encountered.

This has, indeed, been an eventful time and I appreciate very much the opportunity which has been afforded me to participate in it. ★★★

May Is High Blood Pressure Month

Physicians are reminded that May is High Blood Pressure Month. The program objective this year is to increase the number of aware hypertensives who begin, maintain, or resume adequate treatment for the control of hypertension.

The American Heart Association, sponsor of the month, and its affiliates including Mississippi emphasize that this does not mean that efforts directed to screening or detection should be minimized or discontinued. Continuance of such efforts is important, but statistics indicate that several million aware hypertensives are unsuccessful in controlling their disease.

Factors related to this problem include:

- Lack of understanding of the disease and its consequences.
- Patient does not feel ill and therefore does not believe he/she has the problem.
- Patient attitudes toward health and illness.
- Failure to understand the need for life-long treatment.
- Failure to take medication as prescribed, inability to remember details.
- Side-effects of medication and lack of reporting such side effects.
- Failure to keep physician appointments for treatment evaluation.
- Possibly, cost of medication and cost of medical care.
- Inadequate or insufficient communication between treatment personnel and patient and families regarding the illness.
- Lack of family cooperation in the treatment program due to lack of involvement and understanding.
- Lack of or insufficient community resources to assist with the treatment program such as dietary counseling, weight reduction programs, smoking cessation and prevention programs.
- Lack of accessibility of medical care.
- Inconvenience of obtaining medical care in terms of clinic hours, physician office hours, waiting time, etc.

Other economic and social factors.

Language barriers or educational barriers to understanding of the terms used in counseling or instruction.

These reasons suggest that increased efforts in professional and public/patient education are necessary to increase public comprehension of the meaning and significance of hypertension. Increased attention to individual instruction or counseling of screenees with suspected high blood pressure at the time of screening is needed to encourage their seeking medical diagnosis and treatment. Intensifying referral and follow-up methods to increase the number of individuals who report to a source of medical care for diagnosis will be a beginning. Greater attention to those patients who are "repeaters" at screening programs who are not controlled will be a priority of heart association programs in the coming year.

Dr. Walter Rose of Indianola is chairman of the MHA High Blood Pressure Month committee. He and other committee members from various health and social organizations urge physicians to emphasize hypertension checks on all their patients during May.—NG

NEW MEMBERS

BENOIST, LOUIS A., III, Natchez. Born Natchez, MS, Sept. 6, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned Confederate Memorial Hospital, Shreveport, LA, one year; orthopaedic surgery residency, same, one year; orthopaedic surgery residency, Mobile General Hospital, Mobile, AL, 1973-74; orthopaedic surgery residency, Confederate Memorial Hospital, Shreveport, LA, 1974-76; elected by Homochitto Valley Medical Society.

GOLDSTEIN, LAWRENCE S., Jackson. Born Greenville, MS, Dec. 16, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned and ob-gyn residency, same, 1972-75; elected by Central Medical Society.

HAGOOD, CLYDE O., JR., Biloxi. Born Ft. Worth, TX, Jan. 24, 1931; M.D., Tulane University School of Medicine, New Orleans, LA, 1956; interned Charity Hospital, New Orleans, one year; surgery residency, William Beaumont Army Medical Center, El Paso, TX, 1959-63; elected by Coast Counties Medical Society.

MURRAY, JOHN P., Jackson. Born Charleston, WV, April 13, 1941; M.D., Washington University School of Medicine, St. Louis, MO, 1966; interned Medical College of Virginia, Richmond, one year; otolaryngology residency, St. Luke's Hospital, St. Louis, 1967-68; otolaryngology residency, Washington University, St. Louis, 1970-74; elected by Central Medical Society.

RAINES, EDWIN A., Tupelo. Born Memphis, TN, Aug. 15, 1946; M.D., University of Tennessee College of Medicine, Memphis, 1971; interned Baptist Memorial Hospital, Memphis, Jan. 1972-Jan. 1973; pathology residency, same, 1973-76; elected by Northeast Mississippi Medical Society.

ROGERS, PHILIP WORTH, Hattiesburg. Born Gravette, AR, July 1, 1939; M.D., Louisiana State University School of Medicine, New Orleans, 1966; interned U.S. Army Brooke Army Medical Center, Ft. Sam Houston, TX, one year; internal medicine residency, same, 1967-69; nephrology fellowship, 1969-71; elected by South Mississippi Medical Society.

SHOWS, ROBERT M., Jackson. Born Magee, MS, June 21, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Roanoke Memorial Hospital, Roanoke, VA, one year; elected by Central Medical Society.

POSTGRADUATE CALENDAR

May 19, 1977

EARLY DETECTION OF HEAD AND NECK CANCER
Ramada Inn, Greenville

Sponsored by the University of Mississippi School of Nursing, University Medical Center Division of Continuing Health Professional Education and the National Cancer Institute Project for Head and Neck Cancer, in cooperation with the American Cancer Society, Mississippi Division, Inc.

Coordinator:

Dale E. Clark, M.M.S., Mississippi Head and Neck Cancer Network, UMC.

Open to physicians, dentists, RNs, LPNs, dental hygienists and dental auxiliaries, this workshop is one in a series planned to give health professionals new information about head and neck cancer, with emphasis on early detection, coordination treatment and total rehabilitation. Fee: \$10. Credit: 6 contact hours, .6 CEU, Category I, AMA; AAFP.

POSTGRADUATE / Continued

May 19-20, 1977

ALLERGIC DISEASE FOR THE GENERALIST

University of Tennessee Center for the Health Sciences, Memphis

Sponsored by the University of Mississippi Medical Center, University of Tennessee Center for the Health Sciences and Vanderbilt University Medical Center Departments of Allergy and Immunology.

Coordinator:

Bernard H. Booth, M.D., clinical assistant professor of medicine, UMC.

This joint postgraduate education course is designed for internists, pediatricians and family physicians who care for patients with allergic diseases. A cooperative course will be offered at each of the sponsoring institutions over the next three years. Seminar lecturers will be faculty from the three sponsoring universities and from Northwestern University, the University of Colorado and University of San Francisco. Fee: \$75. Credit: 14 contact hours, 1.4 CEU, Category I, AMA; AAFP.

May 23-24, 1977

NEWBORN RESUSCITATION

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine, University of Mississippi School of Nursing and the University Medical Center Division of Continuing Health Professional Education, with support from the Bureau of Community Health Services, Department of Health, Education and Welfare.

Coordinator:

Gwendolyn Bussa, M.N., assistant professor of nursing, University of Mississippi School of Nursing, and instructor in obstetrics-gynecology, University of Mississippi School of Medicine.

Open to physicians, RNs and respiratory therapists, this two-day course will emphasize the manual skill of resuscitation with lectures and practice. UMC faculty will stress management of the mechanical and pharmacological needs of the resuscitated newborn, and how to identify the neonate in need of resuscitation. Enrollment is limited to six. Fee: \$50. Credit: 15 contact hours, 1.5 CEU, Category I, AMA; AAFP.

May 24-25, 1977

CLINICAL RHEUMATOLOGY FOR PHYSICIANS

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine, Mississippi Chapter of the Arthritis Foundation, and the University Medical Center Division of Continuing Health Professional Education, with support from the Mississippi Regional Medical Program.

Coordinator:

James B. Pennebaker, M.D., assistant professor of medicine and director, Division of Rheumatology, University of Mississippi School of Medicine.

This two-day course is designed to increase the knowledge and clinical skills of the family practitioner and internist in rheumatic diseases. Emphasis will be on areas in which there are new techniques available to help in diagnosis and treatment. Fee: \$25. Credit: 16 contact hours, 1.6 CEU, Category I, AMA; AAFP.

May 26-27, 1977

NEWBORN VENTILATION

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine, the University of Mississippi School of Nursing, and the University Medical Center Division of Continuing Health Professional Education, with support from the Bureau of Community Health Services, Department of Health, Education and Welfare.

Coordinator: Gwendolyn Bussa, M.N.

UMC faculty will teach the anatomy and physiology, indications and practical problems of newborn ventilation in this two-day course for physicians, RNs and respiratory therapists. Emphasis is on the initiation, maintenance and nursing care of the neonate on artificial ventilation. Fee: \$50. Credit: 14 contact hours, 1.4 CEU, Category I, AMA; AAFP.

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers intensive refresher courses to meet physicians' clinical practice needs in the specialties most requested. The Mississippi Regional Medical Program partially supports the series open to all physicians. Intensive courses are eligible for AMA Physician Recognition Award, Category 1, credit. Enrollment is limited and applications are accepted in the order received. All correspondence should be addressed to: Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

MEETINGS

National and Regional

American Medical Association, Annual Convention, June 18-23, San Francisco. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Cancer Concepts 1977, Oct. 16-18, 1977, Sheraton Inn, Gatlinburg, TN. For information contact: Dr. Harvey Goodman, Department of Continuing Medical Education, University of Tennessee Center for the Health Sciences, 1924 Alcoa Highway, Knoxville, TN 37920.

Tri-state (MS, LA, ARK) Heart Associations Scientific Session, "Perspectives in Cardiology," May 18-20, 1977, Broadwater Beach Hotel, Biloxi, MS. Bill Dawkins, Program Director, P.O. Box 16063, Jackson, MS 39206.

State and Local

Mississippi Academy of Family Physicians, Annual Meeting, July 6-9 1977, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 109th Annual Session, May 2-5, 1977, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Henry McCrory, Secy., P.O. Box 340, Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. G. L. Arrington, Jr., Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1167, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Thomas Glasgow, Secy., 1196 Mound St., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. George Walker, Secy., 102 W. Lampkin St., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Clyde Gunn, Jr., Secy., P.O. Drawer G, Moss Point 39563. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Thomas Blake, Secy., 424 S. 13th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

*"In a real dark night of the soul
it is always three o'clock in the morning."*

—F. SCOTT FITZGERALD
THE CRACKUP, 1936



Insomnia

a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin[®] (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime.¹ Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO. Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974

Brief Summary of Prescribing Information

ADAPIN[®] (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response.

Usual optimum daily dosage is 75 mg to 150 mg per day, not to exceed 300 mg per day.

Antrianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg and 50 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.

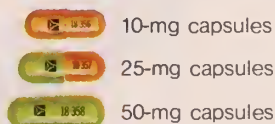


When they see life
in shades of blue...
help them see life
in all its colors.

Adapin[®]

(doxepin HCl)

single daily dose recommended h.s.



PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

Where do you stand on these issues?

Pro Con

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Maternal and child care programs |
| <input type="checkbox"/> | <input type="checkbox"/> | Federal aid to medical students |
| <input type="checkbox"/> | <input type="checkbox"/> | Extending private health insurance to everyone |
| <input type="checkbox"/> | <input type="checkbox"/> | Nationwide program of community emergency medical services |
| <input type="checkbox"/> | <input type="checkbox"/> | Reform of the tort system of malpractice adjudication |
| <input type="checkbox"/> | <input type="checkbox"/> | Maximum Allowable Cost (Drug) Regulations |
| <input type="checkbox"/> | <input type="checkbox"/> | Health Planning Act of 1974 |
| <input type="checkbox"/> | <input type="checkbox"/> | Federal control of the number and location of residences |
| <input type="checkbox"/> | <input type="checkbox"/> | Federal standards for licensure and re-licensure |
| <input type="checkbox"/> | <input type="checkbox"/> | Federal national health service |

If you're for the first five but against the second five, you stand where the AMA stands.

The AMA has vigorously supported virtually all recent legislation to provide more and better health care for the public. The AMA has just as staunchly opposed any plan that would infringe on your right to practice the way you choose.

On such vital issues, the AMA is the most effective and influential spokesman the profession has. With your support, it can be even more effective.



Join us.
We can do much more together.

Dept. of Membership Development
American Medical Association
535 N. Dearborn St./Chicago, IL 60610

Please send me more information on the AMA and AMA membership.

Name _____

Address _____

City/State/Zip _____

PERSONALS

JAMES E. BOOTH of Eupora was re-elected president of the board of trustees of Clarke College and M. L. FLYNT, JR., of Meridian was elected vice president.

RICHARD C. BORONOW of Jackson has been elected president-elect of the National Society of Gynecologic Oncologists. He will take office in January of 1978.

PAUL B. BRUMBY of Lexington has been nominated for Holmes County's Citizen of the Year Award.

REX W. COLLINS of Laurel announces the relocation of his office to 319 South 11th Avenue for the practice of dermatology.

HARRY COSBY, JR., of Iuka is the medical adviser to the health occupations department of Northeast Mississippi Junior College in Booneville.

CLAUDE CROMEANS of Belmont has been chosen as the recipient of the Belmont area Good Citizenship Award for 1977.

LYNN A. DRAKE has begun the practice of dermatology at Senatobia Community Hospital. Dr. Drake completed medical school and residency training at the University of Tennessee.

WILLIAM H. FREDRICK announces the opening of his office for the general practice of medicine at 203-C South Main Street in Newton.

WENDELL N. GILBERT, SR., announces the opening of his office for family practice at 2207 15th Street in Meridian.

JOHN H. JAMES of Petal announces the relocation of The Petal Clinic to 611 South Main.

CHARLES R. JENKINS of Laurel is serving on the American Academy of Family Physicians Chapter Affairs Committee.

ROBERT ASHFORD LITTLE of Gulfport has been elected president of the Board of Directors of Garden Park Community Hospital in Gulfport.

RAY LYLE of Starkville was a guest on the weekly talk show, "Views," on Starkville's community channel. He discussed and answered phone-in questions about concerns relating to children in the community.

GORDON S. MCHENRY of Wiggins ruled as King Zeus at the fourth annual Mardi Gras Ball in Wiggins.

FRANCIS S. MORRISON of UMC presented two papers at the annual meeting of the South Central Association of Blood Banks held in Little Rock. He was also elected vice president of SCABB.

LAMAR PURYEAR of Hazlehurst was guest speaker for the Hazlehurst Lions' Club meeting where he discussed the improvements planned at Hardy Wilson Memorial Hospital.

DAVID OWEN of Hattiesburg is medical director of Home Health Care of Mississippi, Hattiesburg office.

JAMES RATCLIFF of Brooksville served as king of the sixth annual Macon Junior Auxiliary Charity Ball.

J. GEORGE SMITH of Jackson has been appointed to the board of directors of the general Alumni Association and the Medical Alumni Chapter of the University of Mississippi.

S. L. SNYDER has associated with The Vicksburg Clinic in Vicksburg for the practice of internal medicine.

JOSEPH E. SWANTON of Senatobia announces the opening of his office in the Norfleet Medical Building, 403 Norfleet Drive for the practice of obstetrics and gynecology.

ANTONE TANNEHILL, FLOYD L. LUMMUS, EUGENE MURPHEY and WILLIAM L. WOOD, all of Tupelo, announce the consolidation of their practices of internal medicine under the name Internal Medical Associates of Tupelo, Ltd.

MERTON C. TOLER, JR., has entered medical practice with DON BLACKWOOD and PAUL WARRINGTON at the Family Medical Clinic in Cleveland, located at 803 First Street.

GUY T. VISE, JR., of Jackson was a guest speaker at the Mississippi Association of Educational Secretaries' 28th annual spring conference held in Jackson.

W. J. WEATHERFORD of Pascagoula was recognized as the Gulf Coast Chapter's Hall of Fame and National Football Foundation's top contributor to amateur football at the annual banquet in Biloxi.

LETTERS

SIRS: Many people who are allergic to aspirin also are allergic to Tartrazine—especially those over 40 with the symptom complex of nasal polyps and asthma. Recent evidence suggests that aspirin sensitivity with or without nasal polyps may be present in children and adults with intrinsic asthma. In fact, some severe asthmatics may be sensitive to aspirin without realizing it.

It has been estimated that 25-80 per cent of those individuals allergic to aspirin are also allergic to Tartrazine (yellow dye FD&C #5), which is present in some foods, and it is also present in some drugs. Many patients, as well as physicians, are not aware of this.

One such example is the pain reliever, Tylenol, which has been used as a substitute for those sensitive to aspirin—as it contains no aspirin, nor any Tartrazine. However, the medication “Co-Tylenol” does contain Tartrazine. I was made well aware of this fact because of a patient of mine who was referred to me for angiodema and urticaria.

History revealed that aspirin had been taken just prior to the onset of the urticaria and the angiodema. Elimination of the aspirin resulted in the elimination of symptoms. He was given a list of drugs containing aspirin to avoid and also a list of drugs and foods containing Tartrazine. He was told he could use “Tylenol.”

The patient returned last week with severe angiodema and urticaria. He had not taken any aspirin, but he had taken “Co-Tylenol” which was not on the list of drugs I had given him. The company which manufactures “Co-Tylenol” did not give a list of their drugs which contained Tartrazine. A new list has just come out which does list the drugs containing Tartrazine—“Co-Tylenol” is one of these drugs. Tartrazine was not listed on the label of the “Co-Tylenol” as one of the ingredients.

This could cause very severe reactions to someone allergic to Tartrazine. The similarity of names “Tylenol” and “Co-Tylenol” is very confusing and could be dangerous.

CLAUDE A. FRAZIER, M.D.
Doctors Park—Bldg. 4
Asheville, NC 28801

SIRS: Health departments frequently give tetanus toxoid as a part of wound management. Proper management requires a reliable knowledge of the patient's immunization history, the circumstances under which the wound was incurred and its extent.

Protective antitoxin develops rapidly in response to a booster dose in persons who have received, previously, two or more doses of tetanus toxoid. Consequently, Tetanus Immune Globulin (TIG) or antiserum need be considered only when the patient has had less than two doses of toxoid or when the wound has been untended for more than 24 hours. With a history of three or more doses of toxoid, TIG is not used and a booster dose of toxoid is not given more often than every five years.

GUIDE TO TETANUS PROPHYLAXIS IN WOUND MANAGEMENT

<i>History of Tetanus Immunization (Doses)</i>	<i>Clean, Minor Wounds</i>		<i>All Other Wounds</i>	
	TD	TIG	TD	TIG
Uncertain	Yes	No	Yes	Yes
0-1	Yes	No	Yes	Yes
2	Yes	No	Yes	No ¹
3 or more	No ²	No	No ²	No

1. Unless wound more than 24 hours old.
2. Unless more than 10 years since last dose.
3. Unless more than 5 years since last dose.

If antiserum is used, TIG is the preparation of choice. The usual dose, for wounds of average severity, is 250 units. When given concurrently with toxoid, use separate syringes and separate injection sites. Should TIG be unavailable, equine or bovine antitoxin (3,000-5,000 units) may be used, but there is a risk that serious anaphylactic or serum sickness reactions will follow. Its administration should always be preceded by careful screening for sensitivity in accordance with instructions accompanying the antitoxin.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

DEATHS

LINDSEY, WAYNE A., Booneville, M.D., University of Mississippi School of Medicine, Jackson, 1963; interned Baptist Memorial Hospital, Memphis, TN., one year; died Feb. 20, 1977, age 43.

Dr. Jack Schriber Speaks On National Health Insurance

National Health Insurance (NHI) means the federal takeover of the practice of medicine, according to Dr. Jack Schriber of Youngstown, OH,



Dr. Schriber

who spoke to a Millsaps College political science class last month.

Dr. Schriber, a family practitioner and a member of the American Medical Association's Speakers Bureau, pointed out that nationalized medicine is not voluntary; the health care provided would be limited to the amount of money in the treasury.

Nationalized health insurance has been around for about 100 years and most countries now have some form of government medicine, he said. Socialized medicine, an earlier term for NHI, was first proposed in the U. S. by Teddy Roosevelt. Medicare, total health care for the aged, became part of the law in 1965. Next, Medicaid for the poor and medically indigent was enacted.

Traditional reasons given through the years for national health insurance are: medical care costs too much; there are not enough doctors; and the quality of health care in the U. S. is inferior.

Dr. Schriber said the costs *have* gone up in the last 25 years and hospital costs ($\frac{1}{3}$ of health care costs) have quadrupled. Causes include the high labor bill, new equipment and drugs. "We spend more on alcohol, drugs, tobacco and recreation than for drugs and medical care," he pointed out.

"What can the average American afford to pay?" he asked. In 1952, Americans worked 42 minutes to pay for health care; in 1977, they work 36 minutes. Today, 170 million Americans are covered by health insurance and 150 million have major medical coverage.

In 1952, the ratio was 141 physicians to 100,000 population in the U. S. Today the ratio is 180 M.D.s/100,000 population. There are also more

medical schools today; but distribution remains the major problem. This is primarily a social problem, said Dr. Schriber who pointed out that 98 per cent of all Americans live within 25 miles of adequate care.

In regard to the quality of medical care, he said that infant mortality statistics are often used as criteria. This system of comparison is unreliable because different nations utilize different criteria to count infant deaths. In the U. S., infant mortality includes any baby who dies in the first year of life.

He said the AMA's position on NHI is:

(1) Health care is a private, personal responsibility.

(2) Those who cannot pay for medical care (ex. aged, poor, unemployed) should have help.

(3) Federal government should be the last resort.

The AMA has developed a comprehensive health care plan whereby the employer would pay 65 per cent of costs and the employee, 35 per cent. For those self-employed or unemployed, the government would pay partial costs of coverage, according to a sliding scale based on income. This would provide protection against catastrophic illness but build on the present system.

MSMA Answers And Files Suit

The association has filed its initial answer to Governor Finch's lawsuit over appointments to the Mississippi State Board of Health. MSMA asked that the suit be dismissed. A hearing was scheduled on the suit in the Southern District Federal Court on April 27.

In another action the association has filed a "Quo Warranto" suit against Governor Finch's appointees to the Board of Health seeking their removal as "illegal officeholders." The suit was filed in Hinds County Chancery Court.

One of the defendants in the Governor's suit, the Mississippi Optometric Association, has stated its agreement with the Governor and asked to be removed as a defendant. The executive secretary of the MOA is Helen St. Clair, wife of Fred St. Clair, who is one of Governor Finch's top aides. Attorney for the MOA is Senator Nap Cassibry of Gulfport.

ORGANIZATION / Continued

Mississippi Legislature Commends EMC Unit

The 1977 Mississippi Legislature has adopted the following resolution commending the MSMA Emergency Medical Care Unit at the Capitol:

WHEREAS, 1977 begins the seventh term that the Mississippi State Medical Association has provided readily available medical care to the membership of the Legislature by keeping on duty a nurse and a "Doctor of the Day" for emergency medical needs; and

WHEREAS, the presence of such competent and dedicated medical care is a great comfort and reassurance to the members of the Legislature, the staff and often to visitors to the Capitol; and

WHEREAS, it is appropriate that the contribution of time and services by the physicians, nurse and other personnel of the Mississippi State Medical Association be acknowledged:

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF THE STATE OF MISSISSIPPI, THE SENATE CONCURRING THEREIN, That we do hereby recognize the excellent contribution of the Mississippi State

Medical Association to the health and welfare of the Legislators of the state of Mississippi and express appreciation specifically for their services during the 1977 Regular Session.

BE IT FURTHER RESOLVED, That a copy of this resolution be furnished to the Mississippi State Medical Association and to the Capitol Press Corps.

Abbott Labs Honors Mississippi Physicians

Abbott Laboratories has honored four Mississippi physicians for their many years of dedicated medical service to the residents of Mississippi. Each physician was presented an engraved Golden Hour Clock by representatives of Abbott Laboratories.

Honored were Drs. D. H. Thornhill of Gloster, A. P. Durfey of Canton, S. Lamar Bailey of Kosciusko, and Edley Jones of Vicksburg.



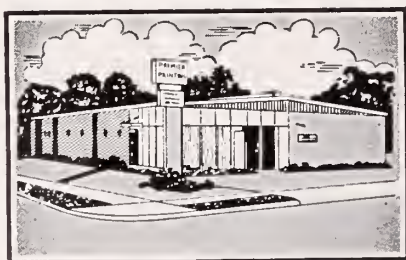
Dr. Edley Jones of Vicksburg, center, receives the clock from Mr. Smith at right, assisted by John W. DuBose, Abbott District Sales Manager.



Dr. A. P. Durfey of Canton, center, displays his Golden Hour Clock which was presented by Mr. DuBose, at left, and Mr. Smith.

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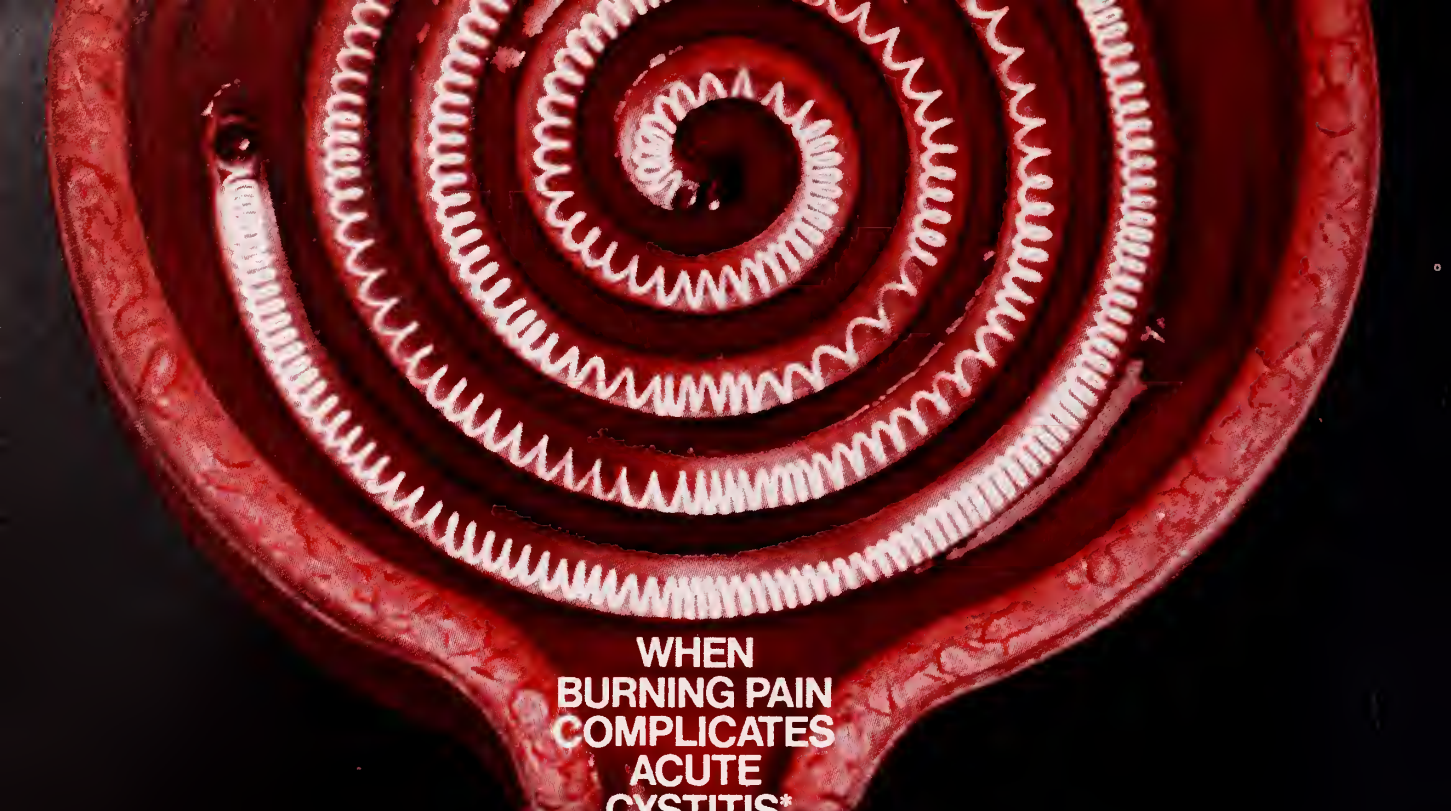
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That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzolic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur, 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity, pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase deficient individuals in whom dose related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura

FOR THE PATHOGENS

- Effectively controls susceptible pathogens such as *E. coli*, *Klebsiella-Aerobacter*, *Staph. aureus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

*nonobstructed due to susceptible organisms

hypoprothrombinemia and methemoglobinemia), allergic reactions (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis), G.I. reactions (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis), CNS reactions (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia), miscellaneous reactions (drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. Usual adult dosage: 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl - bottles of 100 and 500.

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This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

*** Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with

cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy. Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and

leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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Dr. S. Lamar Bailey of Kosciusko, at left, was presented the Golden Hour Clock by Abbott Laboratories professional medical representative, David R. Smith.

MBMC Sponsors Critical Care Medicine Seminar

A seminar emphasizing the basic principles of care of the critically ill patient is being sponsored by the Critical Care services and the Medical Education Committee on May 27-28, 1977, in the Gilfoy Building of the MBMC.

Registration fee is \$35.00 and includes a luncheon honoring Dr. Max H. Weil on Saturday. The seminar is approved for 11 hours, Category I credit, AMA Physicians Recognition Award.

The visiting faculty will feature Dr. Max Weil, director of the Shock Research Unit, Center for the Critically Ill, Los Angeles, CA, along with Drs. Alan Tonnesen, James Arens, Karl Becker, David Glass, Fred Guidry and Joseph Gabel from the Department of Anesthesiology, University Medical Center.

Mississippi Baptist Medical Center staff members who will be on the program include Dr. Harvey Johnston, Dr. Boyd Shaw, Dr. Morris Williams and Dr. Herman Crowder.

Early registration will be appreciated. Make check payable to Education Fund, MBMC. Medical students and physicians in training may attend free of charge, but should send in registration. Contact Dr. John Busey, Director of Medical Education, MBMC, 1225 North State Street, Jackson, MS 39201 for information.

Medical Center Adds to Faculty

Dr. Jose Carranza has been named to the faculty of the University of Mississippi School of Medicine.

His appointment as associate professor of psychiatry and human behavior was announced by UMC Vice Chancellor and medical school dean Dr. Norman C. Nelson following approval of the Board of Trustees, Institutions of Higher Learning.

Dr. Carranza earned his M.D. degree in 1960 from the University of Mexico School of Medicine in Mexico City. He did his internship at Mexico City General Hospital in Mexico City and residency at Norristown State Hospital in Philadelphia.

Dr. Carranza comes to the Mississippi medical school from Houston, TX, where he has been a staff psychiatrist at the Veterans Administration Hospital and a fellow at Baylor University College of Medicine.

He also held fellowships at Hahnemann Medical College and the University of Pennsylvania in Philadelphia, the University of Paris in Paris, France, and Washington Hospital Center in Washington, D. C.

He has served on the faculty at the University of Mexico School of Medicine and staffs of Mexico City Psychiatric Hospital and Sainte Anne Hospital, University of Paris.

Mississippi Now Has a Narcotics Anonymous Chapter

A Mississippi Chapter of the national organization, Narcotics Anonymous, is now in operation. The NA seeks to help addicts and has a 24 hour answering service which directs all calls to qualified counselors. The number is 355-8841.

The Jackson group meets every Monday and Thursday night at 8:00 p.m. at 184 Longino Street.

Narcotics Anonymous follows a program borrowed from Alcoholics Anonymous. The approach to the problem of addiction is that of one addict helping another. NA is a nonprofit fellowship or society of men and women for whom drugs had become a major problem. Membership consists of recovered addicts who meet regularly to help each other in a program of complete abstinence from all drugs.

The only requirement for membership is the honest desire to stop using drugs. There are no leaders, no initiation fees or dues, no pledges to sign. NA is not connected with any political, religious or law enforcement groups. Anyone may join regardless of age, race, or religion.

ORGANIZATION / Continued

Dr. John Young Heads Charity Hospitals Board

Dr. John R. Young of Natchez has been elected chairman of the Eleemosynary Board of Directors for the state's eleemosynary institutions or charity hospitals.

The new chairman, an ear, nose and throat specialist, has been a member of the Eleemosynary board since 1972. A native of Greenwood, he attended medical school at Tulane University, served in the U. S. Air Force and settled in Natchez in 1968.

Dr. Young announced that four new board members are awaiting confirmation, including two physicians, Dr. Chester Masterson of Vicksburg and Dr. Thomas J. Anderson of Laurel.

UMC Will Confer 110 M.D. Degrees

The University of Mississippi Medical Center expects to award a record 311 degrees in the health sciences in the 21st annual Commencement ceremonies Sunday, June 5.

Candidates for the M.D. degree number 110.

The 1977 event is scheduled for 4 p.m. in the Jackson City Auditorium. The day's activities include an annual breakfast for degree candidates and their families, hosted by the medical alumni, and the Chancellor's reception at 2 p.m.

In addition to the M.D. degree candidates, 104 students are candidates for the B.S. in nursing; 38 for the master of nursing; 9 for the B.S. in nurse anesthesiology; 20 for the B.S. in physical therapy; 10 for the B.S. in medical record administration; 14 for the Ph.D. and five for the M.S. in the health sciences; and one for the master of combined sciences. Chancellor Porter L. Fortune, Jr., will confer degrees.

This year's medical record administration students will be the first in the state who are candidates for the B.S. rather than a certificate from the Medical Center. Prior to the change to the upper division baccalaureate program in the School of Health Related Professions, MRA students spent only 11 months on the UMC campus and completed three years of pre-professional study at a college of their choice from which they received the B.S. degree.

Central Auxiliary Sponsors Walk for Mankind

Central Medical Auxiliary again sponsored Jackson's Walk for Mankind in 1977. The Walk is a subsidiary of Project Concern, an international health organization with hospitals and dental clinics in the U. S. and five foreign countries.

Contributions to the Walk are tax deductible and 20 per cent of the money raised by Central Medical Auxiliary members and their spouses comes back to the Auxiliary to be used in its various programs.

Three CMA members officially represented the society, according to Mrs. Ruth Smith, president. They were Mrs. Smith, Mrs. Margaret Campbell and Mrs. Betty Roberts. Dr. William C. McQuinn of Jackson is director of the Walk.

Mississippi Physicians Attend Oncology Course



Among participants in a University of Mississippi Medical Center intensive course on oncology were, from left, Dr. Tom Anderson of the National Cancer Institute in Bethesda, Md., guest lecturer, Dr. Dudley H. Mutziger of Natchez, Dr. E. J. Schmidt of Bude, and Dr. J. Tate Thigpen, UMC assistant professor of medicine and one of the course coordinators. The seminar was sponsored by the UMC School of Medicine and Medical Center Division of Continuing Health Professional Education, with support from the Mississippi Regional Medical Program.

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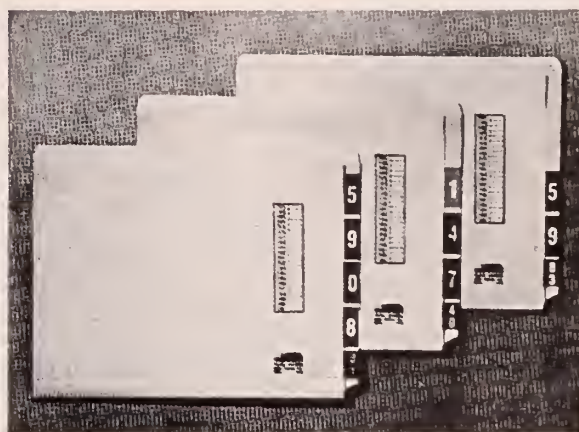
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IN CONCLUSION

AMA Executive Vice President James H. Sammons, in a letter to HEW Secretary Joseph Califano, outlined the difference between "fraud" and "abuse" in federal health care programs. In answering Califano's request, Dr. Sammons said, in part, that "fraud" is a "well-defined legal concept -- misrepresentation with the intent to obtain money or other goods to which one is not entitled..." The word "abuse" is ambiguous, he said, but "should apply to that grey area where appropriateness of the services provided comes into question..."

More than 600,000 Americans are now receiving treatment each year for alcoholism, according to reports recently submitted by the states to the National Institute on Alcohol Abuse and Alcoholism. NIAAA officials estimated that an equal number may be receiving help from Alcoholics Anonymous. Mississippi now has available several services and facilities for treatment of alcoholism including the new Chemical Dependency Unit at Mississippi Baptist Medical Center in Jackson and on-going programs at the V.A. Centers and University Medical Center.

A television film linking suicide and health costs, which drew strong pre-showing protests from the Indiana State Medical Association and the Indiana Hospital Association, apparently will not be used in an advertising campaign planned by the three Health Systems Agencies in the state. Federal funds were used to produce the film which depicts people tumbling from a tall building while the announcer talks about high health costs and also shows a family losing its home and withdrawing its children from school because of high health care costs.

Mississippi is one of thirteen states with high infant mortality rates which will be studied by the American Academy of Pediatrics under a recently awarded contract with the Department of Health, Education and Welfare's Health Services Administration. The academy will study and assess trends and causes behind the high mortality rates. The high rates are often used to compare medical care in the U.S. with that in other countries with much lower rates but which use different methods of recording deaths.

Mississippi notes -- A spot check of Mississippi physicians indicates a diminishing number participating in the Medicaid program. Authorized fees which are now too low to meet expenses and publicity about Medicaid and Medicare payments and abuses are most often cited as reasons... Mississippi's entire congressional delegation has expressed opposition to the FDA ban on saccharin in response to the association's formal protest about the FDA's action which also brought about loud reactions among diabetics and dieters.

LIBRARY

MAY 18 1977

NEW YORK ACADEMY
OF MEDICINE

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient b.i.d. dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require

the BactrimTM 3-system counterattack



Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

June 1977

Journal of the
State Medical
Association

Mississippi



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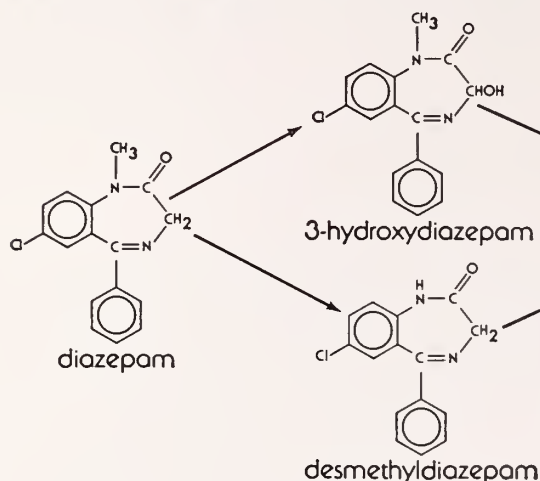
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Physician

Metastatic Melanoma
and Primary
Adenocarcinoma in
the Same Breast

109th Annual Session
Coverage

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) ^{IV}

2-mg, 5-mg, 10-mg scored tablets
a prudent choice in psychic
tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due

to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated:

Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

HOW MUCH DO YOU MAKE?

That's how much you could lose . . . and more . . . if an accident or illness totally disabled you and you were unable to continue your practice. Not only would you lose your personal income, but the cost of maintaining your office would also continue. **YOU COULD LOSE TWICE AS MUCH** as another person might because you have two sets of expenses. To help you fight this possibility, the Mississippi State Medical Association makes available to members two excellent programs that help cover both ends of your expense picture: the **INCOME PROTECTION PROGRAM** for personal expenses, and the tax-deductible **PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM** for your business expenses.

■ TO HELP PAY YOUR PERSONAL EXPENSES, THERE'S MSMA'S INCOME PROTECTION PROGRAM

When you're not practicing, your income stops. Just paying your everyday expenses could run into a great deal of money, draining your savings, especially if your income were cut off indefinitely. The MSMA **INCOME PROTECTION PROGRAM** can pay as much as \$2,000 a month income replacement benefits payable for up to **LIFETIME** for accident-caused disabilities, **TO AGE 65** for disabilities resulting from illness. And, you choose when you want the benefits to begin — either the 31st or the 91st day of disability — to give you the coverage that best fits your own individual needs.

■ TO HELP PAY BUSINESS COSTS, PROFESSIONAL OVERHEAD EXPENSE PROTECTION'S FOR YOU

Whether you're there or not, it costs the same amount of money each month to keep your office open. But, with no money coming in, it could really put you in a serious financial position. You need the business-man's insurance with your practice in mind — the MSMA **PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM**. It works for you when you can't. It'll pay 100% of your covered fixed overhead costs — even up to \$3,500 a month, the maximum amount available. And, the benefits are available for as long as 18 months. Premiums may be deducted as a direct business expense, too.

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Protect yourself and your family. Protect your investment in your business. Find out more about these exceptional MSMA Programs. Write to **THOMAS YATES & CO.**, P. O. Box 1054, Bankers Trust Plaza Building, Jackson, Mississippi 39205 for brochures describing the benefits, features, limitations, exclusions and premiums of each Plan.

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THOMAS YATES & CO. has been awarded the seal of the American Institute of Professional Association Group Insurance Administrators — "In recognition of professional excellence in serving clients with an integrity worthy of the highest trust." Membership in the Institute is by invitation only.

THESE PLANS ARE MSMA SPONSORED

The **INCOME PROTECTION PROGRAM** and the **PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM** are officially sponsored and endorsed by the Mississippi State Medical Association exclusively for its members.

Also sponsored by the MSMA are the **HOSPITAL MONEY PLAN**, **MAJOR MEDICAL PLAN**, **EXCESS MAJOR MEDICAL PLAN**, and **TERM LIFE INSURANCE**. Brochures for these programs are also available.

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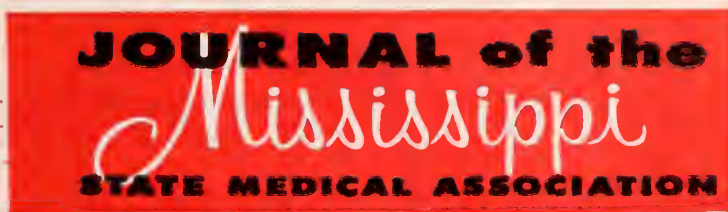
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Volume XVIII

Number 6

June 1977



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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (Publication No. 284800) is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$15.00 per annum; \$2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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All oral bronchodilators are pretty much the same. Right? Wrong!

The difference is in their action—both before and after symptoms begin. That's the reason for TEDRAL[®].

- effective and prolonged bronchodilation from the synergistic effect of ephedrine and theophylline
- β -ADRENERGIC ACTION RELAXES BRONCHIAL SMOOTH MUSCLE
- α -ADRENERGIC ACTION REDUCES BRONCHIAL EDEMA AND SECRETIONS
- dosage forms to meet individual patient needs

For proven performance...

Tedral[®]/Tedral SA[®]/Tedral Elixir[®]

Each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer), 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer), and 25 mg phenobarbital in the immediate release layer

SUSTAINED ACTION

Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital, the alcohol content is 15%.

See next page for brief summary.



WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

T-GP-72-B/W

CAUTION: Federal law prohibits dispensing Tedral SA without prescription.

Description. Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Tedral SA: each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital in the immediate release layer.

Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

Tedral Elixir is convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients; porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to *one-quarter* Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

STORE BETWEEN 59° and 86° F (15° and 30° C).

Full information is available on request.

Physician Ads Don't Help Consumers, Says AMA

The ads promise exciting, fun-filled lives following hair transplants, face and body alteration or wrinkle removal.

"We put it all together at our new Cosmetic Surgery Center," one group's ad boasts. Another advises that "Typically, a patient's total time at the center, from admission through recovery, is approximately six hours." And in another, a supposedly delighted former patient attests, "To say that my life now is more exciting and fun and hassle-free would be the understatement of the last 200 years!"

Physician advertising has been something of a no-no for years. But with the Federal Trade Commission issuing a complaint against the American Medical Association—that its ethical restraints on advertising are anti-competitive—strictures are loosening.

And what sort of advertising seems to be the result? Indications are that few pediatricians are announcing office visits for \$6 rather than \$8. Nor are obstetricians suggesting that their fees for prenatal care and delivery are particularly reasonable. Price competition has scarcely appeared in M.D. ads to date.

The trend seems in another direction, toward what Madison Avenue calls market expansion ads. A sampling of Miami and Los Angeles newspapers turns up ads that simply encourage more people to use more medical services. Such advertising serves mainly to drive the nation's high total medical bill even higher.

"What we are beginning to see," says the AMA's Executive Vice President James H. Sammons, M.D., "is hucksterism. And I don't think hucksterism has a place in medicine."

According to AMA guidelines, however, it is ethical for a physician to make information or intention known to the public. Doctors may furnish such information as their names, type of practice or specialties, office location and hours, even their basic fee structure to help persons make an informed choice when seeking a physician.

But according to the AMA Judicial Council, physicians "should not make extravagant claims or proclaim extraordinary skills. Such practices, however common they may be in the commercial world, are unethical in the practice of medicine because they are injurious to the public."

In December of 1975, the Federal Trade Commission filed suit against the AMA, charging that the association's Principles of Medical Ethics prohibited doctors from generating business by advertising, price competition and competitive practices resulting in restraint of trade. An FTC trial is scheduled for September 1977.

consider the effect on
coexisting diabetes when
you prescribe a vasodilator*



(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the diabetic patient has been reported with

VASODILAN[®]

(ISOXSUPRINE HCl)

the compatible vasodilator

TABLETS, 20 mg.

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg and 20 mg
Vasodilan injection, isoxsuprine HCl, 5 mg. per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

Mead Johnson LABORATORIES

NEWSLETTER

June 1977

Dear Doctor:

Over the past 50 years, the physician population in the United States has been growing twice as fast as the general population. Production of new physicians has been accelerating in recent years, while the growth rate of the general population has been slowing. As a consequence, the physician population since 1970 has been increasing more than four times faster than the U.S. population as a whole, according to AMA figures.

In 1975, there were about 543 potential patients for every physician in the U.S. In 1970, the ratio was 613 persons per physician; and the figure in 1925 was 781. By 1980, according to an HEW projection, the population per doctor ratio is expected to be 490.

As Journal MSMA went to press, a rescheduled hearing on the association's motion to dismiss Governor Finch's SBH suit has been set for June 1 in Federal District Court, Biloxi. Meanwhile in a dramatic new development, Attorney General Summer has filed a "Quo Warranto" suit on behalf of the state in Hinds Circuit Court to remove Governor Finch's illegal appointments to the SBH.

The CHAMPUS program will soon begin paying professional fees in Mississippi based on Medicare reimbursement policies. Blue Cross - Blue Shield of Mississippi, Inc. is now fiscal administrator for CHAMPUS in Louisiana and Mississippi. Blue Cross - Blue Shield will implement the CHAMPUS payment policies in accordance with directives of the Department of Defense.

The Kennedy-Corman bill is costliest, wrote Sylvia Porter, nationally syndicated columnist in her series of articles on national health insurance. To start it would cost employers 3.5 per cent of payroll and the employee 1 per cent on the first \$20,000 of income and 2.5 per cent of interest earned on savings, dividends and other unearned income up to \$20,000 and 2.5 per cent on self employed income.

Hospital costs have risen to the number one health expense taking about 45 cents out of every health care dollar - doctors and other professionals get 23 cents with the rest going for nursing home care, drugs, research and construction. The Health Insurance Institute reports that the proportion paid to hospitals and nursing homes has risen steadily since 1929.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Carter Proposes Hospital Lid

Congress has received its first major health bill from the Carter Administration—a massive and complicated program for limiting hospital revenues to a nine or 10 per cent rise annually. Income from all inpatients, private as well as federal beneficiaries, would be affected.

Hospitals exceeding the allowable increase could be socked with a penalty tax amounting to 150 per cent of the "overcharges." Such offenders also would have to reduce charges the following year.

There is no way the proposal will get through Congress unscathed, experts believe. The lawmakers have been pushing to brake the costs of Medicare and Medicaid, but a cost-control program involving an entire private industry is a different matter. There is almost no sentiment in Congress for a revival of wage-price controls for the economy as a whole.

At the insistence of organized labor, the proposal contains an exemption for hospital wage increases which by itself would appear to blow the nine per cent restraint out of the water. A hospital could adjust upward its permissible revenue by the amount of any wage increase.

Inpatient revenues of the 6,000 acute-care hospitals in this country are covered. Brand new hospitals, federal hospitals, and hospitals controlled by Health Maintenance Organizations (HMO's) would be exempt.

The American Hospital Association charged that the control measure "would severely jeopardize the provision of hospital care to the American public." Hospitals and physicians will unite in opposing it, the AHA said.

"This proposal would not only prevent hospitals from increasing services to patients, it would require some to cut back existing services," said J. Alexander McMahon, president of the AHA, at a Washington, D. C. news conference.

"The real victims would be the sick and injured, and for their sake, hospitals across the country will unite to oppose this bill."

Healing is a matter of time, but it is sometimes also a matter of opportunity.

—Hippocrates, *Precepts*, Ch. 1

BRIEF SUMMARY OF PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate) ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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ORAL SUSPENSION



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pinworm infections

Please see brief summary of prescribing information on facing page.

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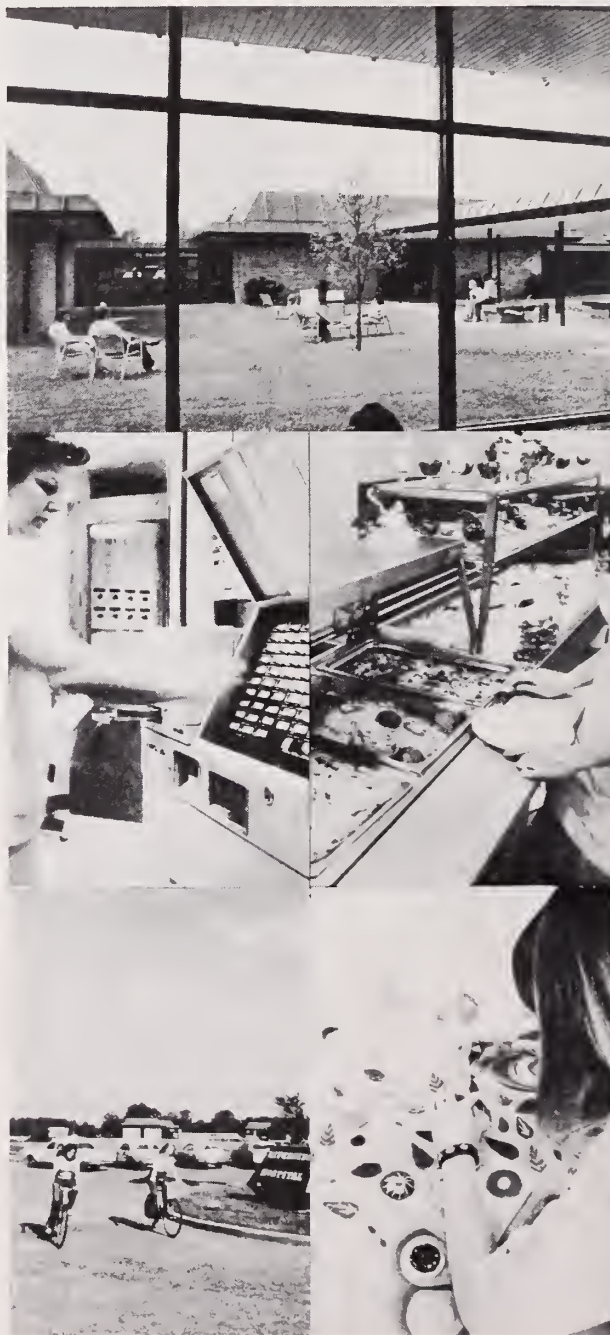
The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

For additional information contact: John R. Reedy, Executive Director.

Riverside Hospital

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Telephone: (601) 939-9030



DATELINE

AMA-ERF Depends on MDs and Spouses Chicago, IL - Every dollar contributed to the American Medical Association Education and Research Foundation medical student loan guarantee program provides \$12.50 in loans from a participating bank to medical students and physicians-in-training. Last year AMA-ERF supported \$7.8 million in loans. Since 1962 it has supported loans of \$77 million. The program depends upon the generosity of the medical profession and medical families for funding.

Drivers' Licensing Standards Are Inadequate Chicago, IL - Some individuals are too emotionally unstable to be trusted to drive an auto, but current psychiatric standards for limiting drivers' licenses are inadequate, according to an article in the May 3 issue of JAMA. The author lists four general categories to consider: intellectual impairment (including senility), impaired perception of reality, suicidal or homicidal inclinations, and/or alcohol and drug abuse.

Cases of Measles Are on the Increase Atlanta, GA - Cases of measles have increased 62 per cent in the last year, with 39,585 reported in 1976, compared with 24,374 in 1975, the Center for Disease Control reports. During the first 12 weeks of this year, more than 16,000 cases were reported, maintaining the 62 per cent increase over last year's 10,000 in the same period. CDC could find no single epidemiological reason for the increase and noted that national immunization levels continue to increase.

Business Consultants Roster Is Available Chicago, IL - The 1977 roster of the Society of Professional Business Consultants is now available to physicians who are interested in locating a business adviser. The Society of Professional Business Consultants is a national organization of practice management consultants who work exclusively for physicians and dentists. To obtain a free copy of the roster, write on professional stationery to SPBC, 221 N. LaSalle St., Chicago, IL 60601.

Hospital Medical Staff Workshop Set Atlanta, GA - In the United States one hospital out of three has no physician on its governing board, according to an American Hospital Association survey. The resulting lack of communication is believed by many to be what leads to disagreements between hospital governing boards and the medical staffs. The American Medical Association will conduct a hospital medical staff workshop in Atlanta, Georgia, June 10-11, 1977, to bring board members and medical staff representatives together to discuss problems.

New Guidelines Offered For X-Rays of Breast

Recent publicity about potential dangers of mammography screening has generated an emotional reaction in both lay and professional circles. Use of diagnostic x-ray when indicated is not in question. The problem comes in the mass screening by x-ray of women who have no symptoms and are not in the high risk groups.

The danger comes from the possibility that the x-ray itself may cause cancer.

American women and often their physicians as well are in a quandary over whether to use x-ray to check for cancer.

There still are some unknown factors in this situation, but, given the present state of medical knowledge, some practical guidelines for mammography are offered in the March 7 *Journal of the American Medical Association* by researchers from the Scripps Clinic and Research Foundation, LaJolla, California:

1. Any woman, regardless of age, with signs or symptoms that indicate breast cancer (such as a lump) should have a mammograph.

2. A woman who has a high risk for breast cancer (strong family history, previous breast cancer, no pregnancy before 30 years of age) should re-

ceive periodic screening examinations, including mammography.

3. Periodic screening should be done for all women over the age of 50 years.

4. Women under 50 years without symptoms should not be screened until further facts are discovered on the benefits and risks.

Harold M. Swartz, M.D., and Barbara A. Reichling of the Scripps Clinic point out that "for any individual woman, the risk of inducing breast cancer by mammography is very low." Mammographs, they say, should be made only with modern equipment and techniques designed to provide optimum information with minimal dose.

In another report in the same issue of *JAMA*, Gerson J. Lesnick, M.D., of Mount Sinai School of Medicine, New York City, reports that x-rays of the breast are of little value in detecting cancer in women under 45 years. In a group of 106 patients under 45 years, 84 per cent had first detected the tumors themselves. Another 14 per cent were discovered by physicians on routine physical examinations.

A third report from Maurice M. Black, M.D., of the New York Medical College, New York City, reveals that there was a great surge of demand for mammography recently following the public dis-

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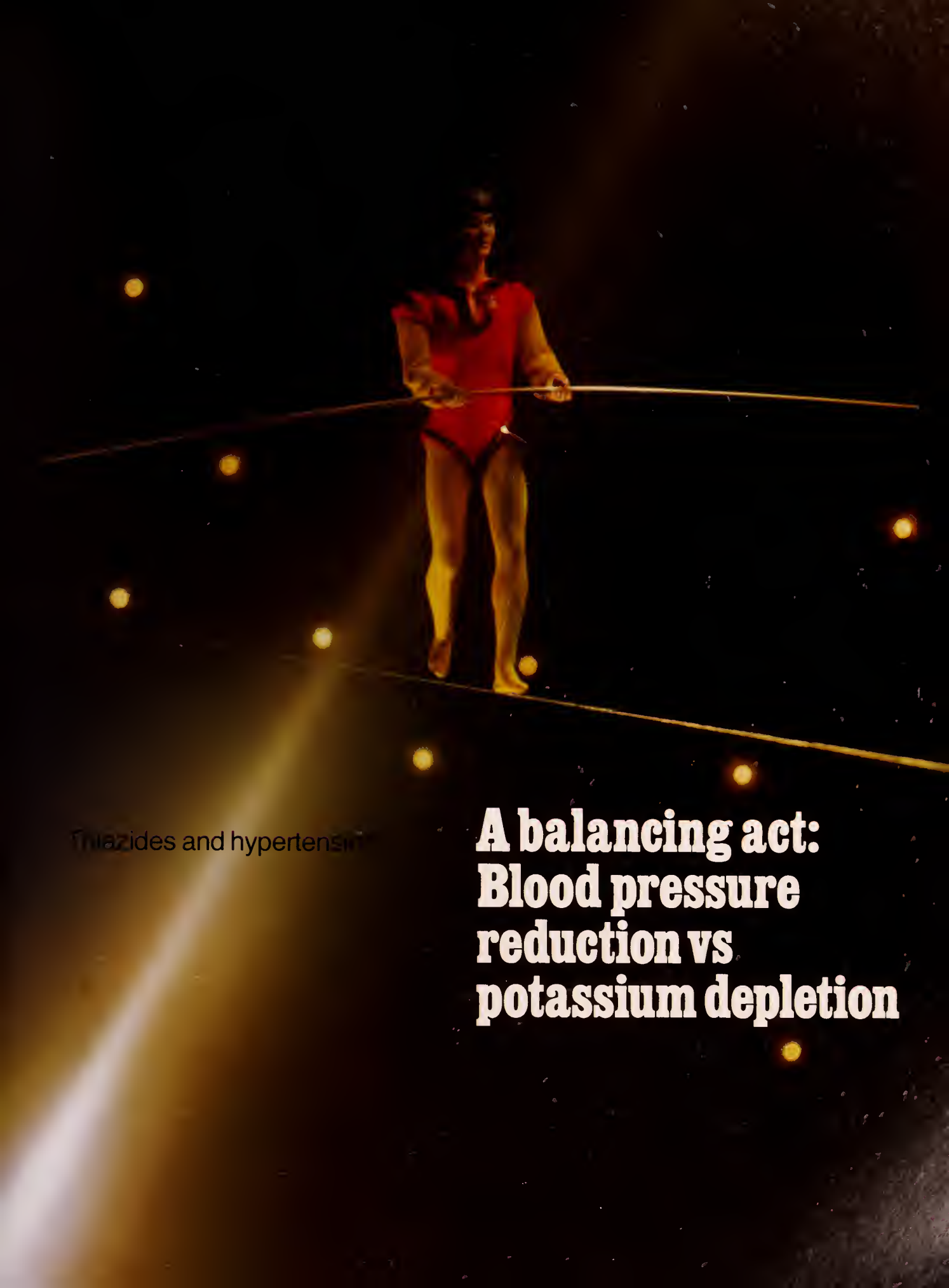
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Thiazides and hypertension

**A balancing act:
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potassium depletion**

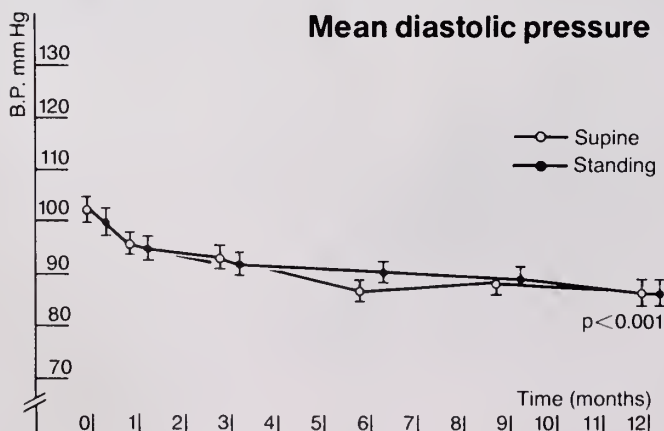
From a 1-year study of 18 patients
with mild uncomplicated
hypertension published in The Lancet*

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"The mean pretreatment blood pressure was 170/103mmHg (supine) and 166/100mmHg (standing). Diastolic pressure continued to fall over the first 6 months and then there was no further change up to 1 year...The mean blood pressure at 12 months was 153/88mmHg (supine) and 142/88mmHg (standing)."

"The patients were receiving a single daily dose of 10 mg bendrofluazide [bendroflumethiazide]...there were no apparent side effects from the medication."

*Wilkinson PR et al: The Lancet 1:759-762, 1975.



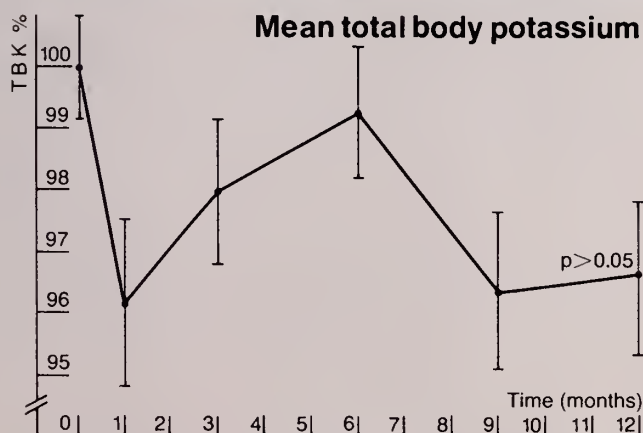
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See next page for full prescribing information.

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NATURETIN®-2.5

NATURETIN®-5

NATURETIN®-10

Bendroflumethiazide Tablets N.F.

DESCRIPTION

Naturetin (Bendroflumethiazide Tablets N.F.) is a benzothiadiazine derivative containing a benzyl and a trifluoromethyl group. It is a potent oral diuretic and antihypertensive agent available as compressed tablets providing 2.5, 5.0, or 10 mg. bendroflumethiazide.

ACTIONS

The mechanism of action results in an interference with the renal tubular mechanism of electrolyte reabsorption. At maximal therapeutic dosage all thiazides are approximately equal in their diuretic potency. The mechanism whereby thiazides function in the control of hypertension is unknown.

INDICATIONS

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated as adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis and corticosteroid and estrogen therapy.

Bendroflumethiazide has also been found useful in edema due to various forms of renal dysfunction such as: nephrotic syndrome, acute glomerulonephritis, and chronic renal failure.

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated in the management of hypertension either as the sole therapeutic agent or to enhance the effectiveness of other antihypertensive drugs in the more severe forms of hypertension.

Usage in Pregnancy. The routine use of diuretics in an otherwise healthy woman is inappropriate and exposes mother and fetus to unnecessary hazard. Diuretics do not prevent development of toxemia of pregnancy, and there is no satisfactory evidence that they are useful in the treatment of developed toxemia.

Edema during pregnancy may arise from pathological causes or from the physiologic and mechanical consequences of pregnancy. Thiazides are indicated in pregnancy when edema is due to pathologic causes, just as they are in the absence of pregnancy (see WARNINGS). Dependent edema in pregnancy, resulting from restriction of venous return by the expanded uterus, is properly treated through elevation of the lower extremities and use of support hose; use of diuretics to lower intravascular volume in this case is illogical and unnecessary. There is hypervolemia during normal pregnancy which is harmful to neither the fetus nor the mother (in the absence of cardiovascular disease), but which is associated with edema, including generalized edema, in the majority of pregnant women. If this edema produces discomfort, increased recumbency will often provide relief. In rare instances, this edema may cause extreme discomfort which is not relieved by rest. In these cases, a short course of diuretics may provide relief and may be appropriate.

CONTRAINDICATIONS

Bendroflumethiazide is contraindicated in anuria.

It is also contraindicated in patients who have previously demonstrated hypersensitivity to it or other sulfonamide-derived drugs.

WARNINGS

Bendroflumethiazide should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may be additive or may potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers. Thiazides appear in breast milk. If use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS

Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: dryness of the mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes mellitus may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS

Gastrointestinal System: anorexia, gastric

irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), and pancreatitis.

Central Nervous System: dizziness, vertigo,

paresthesia, headache, and xanthopsia.

Hematologic: leukopenia, agranulocytosis,

thrombocytopenia, and aplastic anemia.

Dermatologic-Hypersensitivity: purpura,

photosensitivity, rash, urticaria, and

necrotizing angitis (vasculitis, cutaneous

vasculitis). **Cardiovascular:** orthostatic

hypotension may occur and may be

aggravated by alcohol, barbiturates or

narcotics. **Other:** hyperglycemia, glycosuria,

occasional metabolic acidosis in diabetic

patients, hyperuricemia, allergic

glomerulonephritis, muscle spasm,

weakness, and restlessness.

Whenever adverse reactions are moderate

or severe, thiazide dosage should be

reduced or therapy withdrawn.

DOSAGE AND ADMINISTRATION

Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

Diuretic: The usual dose is 5 mg. once daily, preferably given in the morning. To initiate therapy, doses up to 20 mg. may be given once daily or divided into two doses. A single daily dose of 2.5 to 5 mg. should suffice for maintenance.

Alternatively, intermittent therapy may be advantageous in many patients. By administering the preparation every other day or on a three to five day per week schedule, electrolyte imbalance is less likely to occur; however, the possibility still exists.

In general, the lowest dosage that achieves the therapeutic response should be employed.

Antihypertensive: The suggested initial dosage is 5 to 20 mg. daily. Maintenance dosage may range from 2.5 to 15 mg. per day, depending on the individual response of the patient. When the diuretic is used with other antihypertensive agents, lower maintenance doses for each drug are usually sufficient.

STORAGE

Store at room temperature; avoid excessive heat.

HOW SUPPLIED

2.5 mg. tablets in bottles of 100, 5 mg. tablets (scored) in bottles of 100 and 1000, and 10 mg. tablets (scored) in bottles of 100.

SQUIBB®

closure that the wives of the President and the Vice President of the United States had been treated for breast cancer.

But, says Dr. Black, there was virtually no impact on the rate of diagnosis and cure of breast cancer.

In an accompanying editorial, John C. Bailar III, M.D., of the National Institute of Health, Bethesda, Md., recommended a somewhat higher age—60 to 65—for the beginning of periodic screening of women without symptoms.

Rough estimates indicate that the present practice of mammography used as preventive screening may eventually induce some breast cancers if it is used indiscriminately to examine all women more than 35 years of age, says Dr. Bailar. Older women probably benefit more from mammography than they lose, he says.

Mississippi Council on Epilepsy Explains Goals

Although we live in what we consider a very educated society, fear, ignorance, and misunderstanding still surround the disorder—epilepsy. The Mississippi Council on Epilepsy points out that anyone can develop epilepsy.

A nonprofit organization, the council has as its purpose to further by all proper means the health, morale and general welfare of persons with epilepsy and to improve their social relationships.

Goals of the council are:

1. To be repository for, or a guide to, all available information on the epilepsies.
2. Encourage and support research at the national level relating to the cause of epilepsy. Such research shall be designed to prevent seizure disorders or to minimize the effects of epilepsy to persons who have the condition.
3. Educate and provide information to the person with epilepsy about his disorder, and to the general public, on the epilepsies as a method of reducing fear and stigma that still surround this disorder.
4. Provide and encourage professional education for many disciplines in diagnosis, treatment, rehabilitation and employment placement of persons with epilepsy.
5. Act as advocate to assure that persons with epilepsy receive their civil, legal, and human rights.

The council is located at 969 Lakeland Drive, Jackson, MS 39216. Greg Adams serves as president.

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**Mississippi Council of
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Medical Center Adds to Faculty

Three new faculty have been added to the University of Mississippi School of Medicine at the Medical Center.

They are Dr. Robert Lee Britt, assistant professor of pediatrics; Dr. Luther Calvin Fisher, III, assistant professor of surgery (orthopedics); and Dr. Frederick R. Heckler, assistant professor of surgery (plastic).

The appointments were announced by UMC Vice Chancellor and School of Medicine Dean Dr. Norman C. Nelson following approval of the Board of Trustees, Institutions of Higher Learning.

Dr. Britt, who will also be director of University Hospital's pediatric outpatient department, is a graduate of Purdue University and earned his M.D. degree at the University of Cincinnati School of Medicine. He did his internship at Metropolitan City Hospital in New York City and his residency at Vanderbilt Hospital in Nashville. In private practice in Evansville, IN, since 1952, Dr. Britt will join the faculty in June.

Dr. Fisher attended Emory University and received his M.D. degree at Tulane University School of Medicine. He took his postgraduate training at Charity Hospital in New Orleans and UMC. Dr. Fisher comes

to UMC from Houston, TX, where he has been in private practice. He will assume his duties July 1. Dr. Fisher has served as an instructor at the Medical College of Georgia Hospital and Clinics in Augusta and as chief of the rehabilitation branch, All-Africa Leprosy and Rehabilitation Training Center, Addis Ababa, Ethiopia.

A graduate of Tufts University School of Medicine in Medford, MA, Dr. Heckler did an internship at the University of Chicago Medical Center and residencies at Tufts New England Medical Center in Boston and the United States Air Force's Wilford Hall Medical Center in San Antonio, TX. He also did fellowship work at Malmo General Hospital in Malmo, Sweden.

Medical Assistants Hold Annual Convention

The Eleventh Annual Convention of the Mississippi Society, American Association of Medical Assistants, Inc., was held April 15-17 at the Broadwater Beach Hotel in Biloxi. The theme was "Always Aware of Medical Advancement." Helen Donohoo, CMA-A president, was presiding officer.

Mrs. Wini Schwartz, CMA-AC, vice-president, AAMA, was present and conducted a workshop on medical law and ethics.

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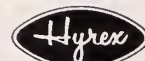
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Charles Mathews, MSMA Executive Secretary, was guest speaker at the installation banquet Saturday night, April 16. The following were installed by Mrs. Schwartz: Peggy Long, president; Ethel Tatum, president-elect; Edith Walden, vice-president; Georgia Morrow, secretary; Marian Cook, treasurer. Dr. H. K. Rouse, Jr., of Gulfport was selected as Doctor of the Year.

Dr. W. T. Oakes of Amory, Dr. Edwin Hemness of Clarksdale and Dr. Daniel L. Thornton, Jr., of Meridian were selected as state advisors to serve with Dr. Richard Burman of Gulfport and Dr. Guy Campbell of Jackson.

Nation's Health Is Good

The nation's health shows steady improvement, according to a 25-year mortality survey by the National Center for Health Statistics.

Since 1950, the death rate from stroke and heart disease declined steadily in those aged 25 to 74 and deaths from tuberculosis, once a leading cause, now number 3,000 annually.

The mortality rate from heart disease dropped 30 per cent in those aged 45 to 74, with the biggest gains coming in the last six years.

The death rate from stroke fell even more sharply during this period—a 50 per cent decline for the 45-64 age group and a 45 per cent reduction for those 65 to 74.

The aging of the entire U. S. population is demonstrated by the decline in the overall death rate. After leveling off in the 1960's the death rate has steadily declined in the 1970's and reached an all-time low in 1975 of 8.9 deaths per 1,000 population.

Lung cancer had the biggest jump in death rate, doubling in men and going up four times in women since 1950.

The increase has offset declines in the death rate from cancer of the stomach, rectum, cervix, and uterus.

Infant mortality declined from 29.2 to 16.1 deaths per 1,000 live births, but the United States still ranks 15th in infant mortality. "The total rate . . . masks persistent differences for major population groups. The death rate for black infants is 41 per cent higher than for whites, and for black infants the mortality rate during the first four weeks of life (18.3 per 1,000 live births) exceeds the death rate of white infants during their entire first year of life (14.2). This was attributed to the high birth rate among black teenagers with the attending lack of adequate prenatal care."

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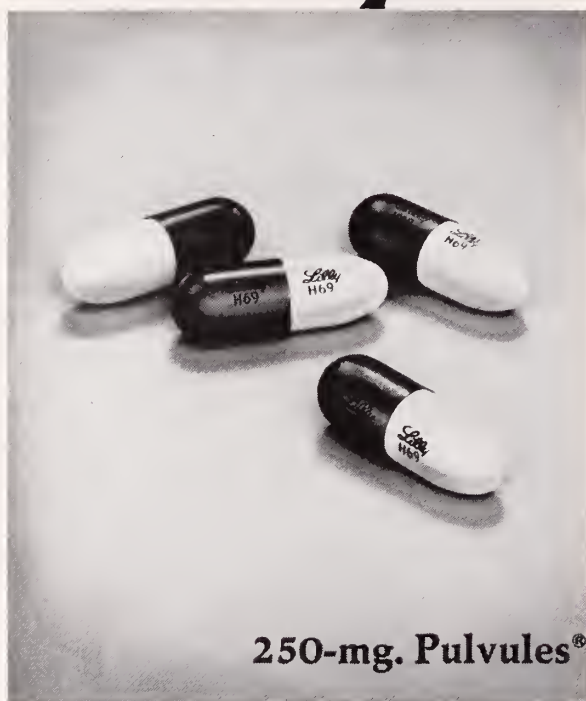
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ORIGINAL PAPERS

Pain and Malignancy

BERNARD S. PATRICK, M.D., GLENN GATIPON, Ph.D., and
ROBERT A. SANFORD, M.D., Jackson, Mississippi

PHYSICIANS HAVE long accepted the concept that pain served as a protective function in alerting the individual to the threat or presence of disease or injury. Leriche¹ in his writing of surgery of pain, associated with cancer, causalgia, etc., expressed opposition to this concept, stating, "I would oppose this extraordinary error, whose persistence I fail to understand. . . ."

Bonica,² in his classic and comprehensive book, *Management of Pain*, reconciled both viewpoints in his statement, "I interpret pain in its initial phase as a physiological sensation with the function of warning the organism that its integrity is disturbed and is in danger; whereas in its late phases, when it becomes intractable, it no longer serves a useful purpose and then becomes, through its mental and physical effects, a destructive force."

Thus, acute pain is a symptom; chronic pain can become a disease.

Physiology of Pain Perception

Certain aspects of the physiology of perception of pain set it apart sharply and distinctly from other

sensory modalities. Wolff,³ using a dolorimeter,* found that a stimulus approximately twice that of threshold stimulus produced maximal pain above which the degree of pain did not increase even with increased strength of stimulus. This he called "ceiling pain" (see Figure 1).

This is the first of a series of articles dealing with pain associated with malignant neoplasms. General concepts of the physiology of pain and pathophysiology of pain of malignancy are discussed. Subsequent articles will deal with the management of pain of malignancy.

This narrow range between threshold and ceiling pain is a point of differentiation between pain sensation and other sensations. Whereas the range between threshold and maximal warmth sensation is one to two thousand (1 : 2,000), the range for pain is one to two (1 : 2).⁴

In contrast to other sensations, such as cold or warmth, pain perception lacks spatial summation.⁵ That is, the intensity of pain is dependent upon the intensity of the stimulus and not upon the size of the area involved; or the intensity of two pains existing separately at the same time is no greater than the intensity of the more severe of the two pains. There may be a physiologic basis for this as this would tend to protect an organism from being overpowered by pain impulses which might otherwise prevent it from acting in its fight or flight from danger.

Lack of adaptation, or habituation, further sep-

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* An apparatus used in measuring pain perception in which a light of measured intensity is focused on a black (India ink) spot on the skin of the subject.

Ed. Note: This series was accepted for publication in January of 1977, before a new JOURNAL MSMA policy was enacted by the Committee on Publications. As of May 2, 1977: "No series of papers will be accepted by the JOURNAL MSMA. All articles must be submitted on an individual basis to the appropriate editor for review and acceptance. Articles should be of a practical orientation aiming toward the general physician."

arates pain from other sensations. Other sensory modalities, if subjected over a period of time to a continuing stimulus of constant nature, tend to show a diminishing rate of discharge of impulses which is called adaptation.³ Pain receptive or perceptive mechanisms do not exhibit such a phenomenon and pain fibers continue to receive and conduct pain as long as the stimulus is applied, and as long as the fiber is intact. This suggests further programming of physiology toward self-preservation.

Gate Theory

In recent years, new interest has developed in pain control, in part by the wave of interest in acupuncture and the subsequent endeavors to control pain by various techniques of electrical stimulation.

The term "gate theory" is often used in discussing the pain control mechanism theory published in 1963 by Melzack and Wall.⁶ They stated that, at the site of entrance of sensory input to the spinal cord, a controlling mechanism exists in the substantia gelatinosa.

Neurons in this area are capable of modifying the pattern of nerve impulses which enter the pain pathways and are interpreted as pain. The action of these cells in the substantia gelatinosa can be influenced by other sensations coming from the periphery or by impulses descending in the cord from higher centers of the brain.

As illustrated in Figure 2, substantia gelatinosa (s.g.) cells normally exert a mild inhibitory action on impulses arriving via the small "C" fiber. Neurons of the s.g. cells synapse with transmission, or "T" cells, which feed into the pain pathways to the brain. When pain impulses arrive in the cord, they

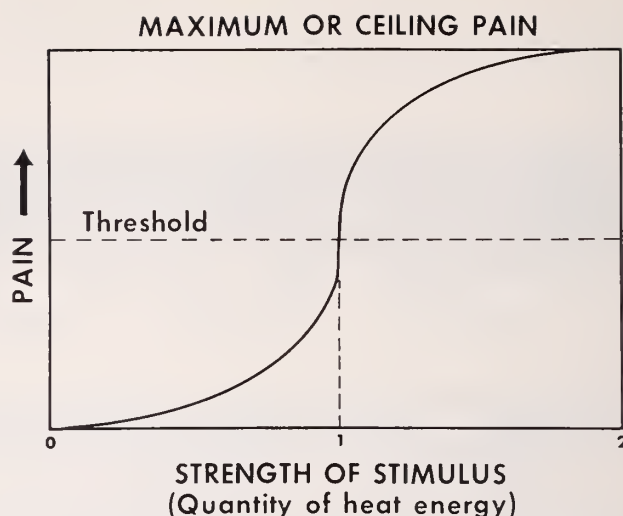


Figure 2

inhibit the s.g. cells which cease to inhibit the "C" fiber-"T" cell synapse. Thus, when the slow conducting "C" fiber alone is stimulated, it, so to speak, inhibits the inhibitor, thereby facilitating pain transmission.

Conversely, more rapidly conducting "A" fibers, carrying pressure, vibration or other sensations, when stimulating the s.g. cell, cause it to increase its pain-inhibiting activity. Thus "A" fibers stimulate the inhibitor, closing the gate, whereas "C" fibers tend to inhibit and open the gate.

This gate control concept is further postulated to act, not only at the spinal cord level at the site of input of the posterior root, but also at successively higher levels in the nervous system, such as the mid-brain (reticular activating system) and thalamus.

Although now in question, the gate theory has been a theoretical fulcrum for renewed interest in pain mechanisms, and has provided the rationale for recent pharmacological approaches and clinical techniques designed to reduce chronic pathological pain.

Reaction to Pain

Factors other than distraction such as auto-suggestion, intense concentration, or hypnosis have been found to raise the pain threshold to as much as 45 per cent above prior levels.⁷ Wolff and Goodell⁷ observed that in suggestible subjects, placebos could raise the pain threshold as much as 31 per cent. Aspirin alone was found to usually raise the pain threshold about 35 per cent. When given to subjects prejudiced against aspirin, this was found to still raise the pain threshold 23 per cent.

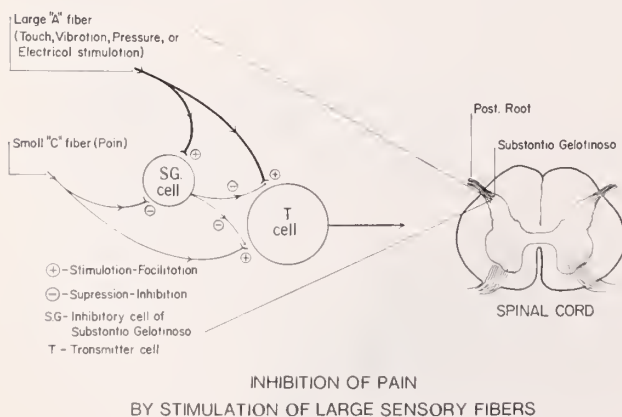


Figure 1

Whereas perception of pain is the awareness of pain, the *reaction* to pain can be considered the expression or evidence of sensitivity to pain.

In the laboratory perception of pain can be tested and measured, but in clinical practice it is difficult to separate it from the reaction to pain and even more difficult to separate it from the psychological factors which tend to influence the patient's reaction to pain.

It has been noted that, whereas distraction can raise the threshold of perception of pain,⁸ it can also markedly raise a person's threshold of reaction to pain. Under extreme circumstances these two thresholds together may be elevated above the level of ceiling pain to the point that a person might experience a severe injury and either not feel it, or be able to ignore it completely. Examples of this are injuries sustained during combat in which a soldier may sustain a severe injury and be quite unaware of it or indifferent to it. Lesser examples occur on the football field when athletes often sustain lacerations or minor fractures, and experience no pain with the injury until after the play or the game is over.

Fatigue tends to modify the reaction to pain by lowering the threshold of pain reaction. Elderly people seem less susceptible to pain than young or adolescent individuals. Women, in general, have a lower pain reaction threshold than men.⁹ Neurotic patients have been found by Chapman¹² and his associates to have significantly lower threshold values for pain reaction than normal subjects. Racial and cultural characteristics tend also to play a role in pain reaction thresholds. For example, Sherman¹⁰ found that, in young coal miners, 75 per cent had higher pain reaction thresholds than the average population. Dark skinned races and northern Europeans have a relatively higher reaction threshold, whereas the southern Europeans have a relatively lower reaction threshold.¹¹

Analgesics, such as alcohol and opiates, though having a fairly uniform effect of elevating pain perception thresholds, may produce a wide variation in the threshold of reaction to pain in different individuals varying from 50 per cent to 800 per cent elevation of pain reaction thresholds.¹³

Pain of Malignant Neoplasms

Malignant tumors, both local and metastatic, present certain special problems in pain control. Generally, the advancement and growth of malignant tissue is too fast to permit normal tissues to accommodate to the new and increasing mass. This results

in considerable stretching and/or displacement of normal tissues. Due to the invasive nature of malignant cells which compete for nutrients and blood supply, destruction of normal tissue ensues in certain cases. This destruction may be seen in certain lesions in or near the skin. Here tissues can expand and, though erosion of the skin surface may occur, these lesions are rarely painful. Malignant lesions developing in muscle tissue or in the tissues of soft internal organs are also rarely painful due to the ability of surrounding tissues to accommodate to the mass.

On the other hand, malignant tumors developing in areas where expansion is limited or retarded by non-elastic tissues most often account for the intractable pain of malignancy. Examples of this are metastases to bone, metastases to retroperitoneal areas and areas beneath the pre-vertebral fascia, in which cases expansion of a rapidly growing mass is limited or impeded by these relatively non-elastic tissues. This results in an inordinate amount of stretching of tissue and associated nerve fibers or results in the trapping and compression of nerves against bone. Either circumstance may produce intractable pain.

Metastases within bone may be painless even while considerable destruction takes place but, when the tumor enlarges or extends sufficiently to stretch the periosteum, then again intractable pain may ensue.

Therefore nerves or nerve roots, when invaded directly by malignant cells, are often destroyed without producing pain if the invasion takes place under circumstances where the nerves are neither compressed nor stretched. Yet, when nerves are trapped against bone or unyielding ligaments, then intense radicular or localizing pain may occur. In short, neoplasms developing in soft freely movable tissues are generally painless whether benign or malignant. Neoplasms developing in or adjacent to bone, particularly adjacent to the vertebral column, tend to produce chronic intractable pain depending somewhat upon location and rate of growth. A very slow growing tumor may produce minimal or no pain, whereas rapidly growing tumors, benign or malignant, occurring adjacent to the spine are more likely to create intractable pain.

Other factors influencing the special nature of pain in malignant disease include cachexia and fear. The debilitated cachectic state of most patients with advanced malignancy tends to markedly lower the thresholds of pain perception and reaction. Where

PAIN AND MALIGNANCY / Patrick et al

narcotics have been used repeatedly and frequently, the threshold of pain perception may be lowered to the point that many patients have almost no tolerance to even small degrees of pain.

The very knowledge of the presence of malignancy, or the fear of this possibility, are severe contributors toward increased reaction to pain. In some cases, severe anxiety results from fear by the patient that he may develop severe pain and not have readily available means of relief. A clear demonstration of this point are those cases in which the patient pleads for the availability of strong narcotics for relief of chronic recurring pain only to discover that, when strong narcotics were placed in the patient's hands and kept readily available, they were seldom or never required.

The unrelenting nature of pain of malignancy, coupled with fear of the disease, fear of death or possible worsening pain, superimposed on a progressively cachectic patient, create perhaps some of the most difficult problems of pain management encountered in medicine. These patients most of all need a close relationship to their physician which provides the confidence and assurance that the patient will not be allowed to endure undue suffering. That such a patient will die may not be preventable,

but that he endures agony of severe pain—this can be avoided. ★★★

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(The next article having to do with management of pain of malignancy will appear in the September issue of this JOURNAL.)

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FUTURE REPORTERS?

A name-recognition test was recently given to freshman journalism students at the University of Connecticut. Some of the answers:

Griffin Bell was the inventor of the telephone.

Jim Beam is the mayor of New York.

Tip O'Neill was President Ford's campaign manager.

Eldridge Cleaver is a former head of the FBI.

The Psychiatrist as a Physician

G. O. RUNNELS, M.D., Hattiesburg, Mississippi

THE PURPOSE OF this writing is to encourage psychiatrists to maintain and increase their role as physicians with special expertise in diagnosing and treating patients with emotional disorders. Garfield Turney, in his 1969 article "History of Biological Psychiatry in America," opened with this statement, "The history of psychiatry presents a progressive spiral with various themes and movements, fads and behaviors, theories and facts aimed at the understanding and treatment of mental disorders."¹

As we look at the various movements in psychiatry, we find in the Greco-Roman period the influence of the church and physicians such as Aesculapius, Hippocrates and Galen. During the Dark Ages the influence of the church was the strongest in dealing with the mentally ill. The 17th century brought back the influence of philosophers such as Francis Bacon.

The 18th and 19th centuries put the focus on physicians such as William Cullen, Johann Reil, Phillip Pinel, Benjamin Rush, D. H. Tuke, and the 1844 formation of the American Psychiatric Association, then called the Medical Superintendents of American Institutes for the Insane.

In the 20th century we see the influence of Sigmund Freud's work on dreams and infantile sexuality. From this movement psychiatry slipped into the realm of many new philosophies and nonphysician analysts were introduced. Freud isolated himself from the medical community leading many to feel that psychiatry was more a cult than a specialty.²

Dougland D. Bond, John Fleumerfelt, and Normal L. Roulet wrote in 1964 that "not too many years ago psychiatry was then a strange specialty, practiced by physicians who were often thought a little strange themselves."³

Meduna, Sakel, Cerletti, and Bini, with the use of convulsive therapy, made psychiatry a definite branch of medicine, as these were all medical procedures. This movement was further supported by the advent of psychopharmacology in the early 1950's by the work of Gene Delay with chlorpromazine,

Frank Burger with meprobamate, J. F. Cade with Lithium and other new developments in the use of drugs in the treatment of the mentally ill.

This article is a collection of data and opinions supporting the psychiatrist's need to maintain his role as a primary physician. The data show that over 50 per cent of psychiatric patients in two studies had associated physical ailments.

Data from two other studies show that two to three per cent of all patients admitted to a general hospital in a metropolitan area for physical ailments also have psychiatric consultations.

The psychiatrist's image in a medical community is studied in two surveys, the basic data of one survey being included.

Adolph Myers' psychobiology helped to make psychiatry a more acceptable medical specialty.²

The earliest work in group therapy was done by an internist, Joseph Henry Pratt, in 1907 when he worked with TB patients in a group process. In 1919 L. P. Cody Marsh followed Pratt's example using group therapy in an institutional setting with mental patients.

World War I brought on the beginning of community psychiatry in caring for the large number of veterans whose needs made it necessary for psychiatrists to start using nonprofessional people in the rehabilitation process. This concept was expanded by the GAP and by William Menninger after World War II. With the aid of this group, the fields of government, law, education, child care, geriatric and other social areas were studied from a psychiatric viewpoint further expanding the nonprofessionals in the care of the mentally ill.

During the 1970's, we have been influenced and aided by other professions. Ian Gregory in *Fundamentals of Psychiatry* gives the historical introduction to psychiatry: "The term is derived from Greek

Dr. Runnels is in the private practice of psychiatry at Hattiesburg.

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roots meaning mind healing and was widely adopted during the latter part of the 19th century, as reflecting appropriate medical concern and responsibility for the care and treatment of patients with mental disorders. The psychiatrist is therefore a physician with special training and experience in evaluation of patients with psychiatric disorders.”⁴

Now I fear that all too many of us are willing to relinquish our medical role in search of other forms of therapy forgetting that in 1966 Frederick Redlick and Daniel Freeman quoted, “a young field, psychiatry has become firmly established as a medical discipline, yet it borrows heavily from the social sciences.”⁵ Also “that psychiatry, the oldest member of the mental health profession was the first to come to professional maturity.”⁶

Robert Felix has strongly reminded psychiatrists that “they are physicians and that their unique contribution to the mental health field lies in the fact that they are the only mental health specialists who have competency in medical and psychological techniques in diagnosing and treating behavioral disorders.”⁷

For years analysts and other psychiatrists avoided touching and examining patients under the guise that it made the transference problem more difficult to manage. I strongly suspect that for those not involved in intensive psychoanalytic psychotherapy, this was an excuse to avoid what was an unpleasant task.

It is just a lot of trouble to tend to the physical aspects of the patient and even more trouble to keep abreast of the growing scope of medicine, but unless we do, we are guilty of the same incompleteness that we blame other specialists for who only treat the heart, head, stomach, ears, etc. with no interest in the patient as a whole.

Shortly after completing my residency training in psychiatry, I worked in a large mental health center associated with a hospital that had just become accredited by the Joint Commission and thus requiring that all patients have a complete physical examination. Immediately it was evident that there was no way to get this done except that the psychiatrists do it. We put up all the customary complaints about physical contact with patients and transference problems when really it was just a job we didn’t want. Having no choice but to do this, we found it rewarding to us and our patients in that no longer did we have to worry about whether or not other physicians had given the patient’s physical aspect due consider-

ation or just sloughed the patient off as another crock.

The private practice of psychiatry requires that we keep aware of the patient’s physical aspects as I doubt that we can relieve the emotional problems when our patients may be suffering with ulcer pains, uncontrolled diabetes, pernicious anemia, hypothyroidism, etc. We can hardly expect the patient to feel better from his emotional distress until his physical problems have had proper treatment.

I am amazed at how many of my patients have associated physical disorders. A recent audit done in the Forrest General Hospital on our 20-bed psychiatric unit revealed that 50 per cent of the patients had a physical ailment that needed treatment while they were receiving appropriate treatment for their emotional disorder. During one of our slow months in early 1976, the following utilization audit was done on the unit.

PSYCHIATRIC PATIENTS

Number patients admitted with psychiatric diagnosis . . .	24
<i>Treatment:</i>	
Psychotherapy	24
Chemotherapy	20
Group therapy	17
O.T.	9
Convulsive therapy	1
Other (marital session x 2)	1
Average length of stay (days)	9
Consult obtained by other physicians:	
Yes	12
No	13
<i>Special Studies:</i>	
EEG	2
Brain scan	1
Skull films	1
G.I. series	5
G.B. series	3
B.E. series	8
Cultures	3
G.U. studies (x-ray)	2
L.P.	1
EKG	12
Chest x-ray	12
Injuries occurring during hospital stay (small abrasions, arm and leg)	1
Disease other than psychiatric	11
<i>Follow-Up Plan:</i>	
Outpatient therapy	20
State hospital	1
Other hospital	1
Mental health center	1
Home health	1
Nursing home	0
Other (rehab. referral)	1

The common psychiatric diagnosis of depression

was present in 14 of the 24 patients. Three patients had problems with alcohol and other psychiatric diagnoses included two organic brain disease, two adult situational reactions, two cases of drug dependency and one case of schizophrenia.

Medical problems seen in these patients were congestive heart failure, neurodermatitis, urethritis, cystitis, epilepsy, bronchitis and hiatal hernia. Consultation with other physicians was obtained in half the cases. Our average consultation rate with non-psychiatric physicians in a random three-month survey was 53 per cent. This high rate of consultation may suggest that we are insecure in our own role as physicians.

Our findings were similar to a study done by Stewart Shevitz, Peter Silberfarb, and Z. J. Lipowski on 1,000 medical and surgical patients referred for psychiatric consultation. They found concurrent physical ailments associated with psychiatric disorders in 68.2 per cent of the cases.⁸

A 90-day survey throughout Forrest General Hospital, excluding pediatrics, revealed that 2 per cent of all patients admitted to the hospital for any cause received a psychiatric consultation during their hospital stay.

The psychiatric consultation rate was approximately 3 per cent for all patients admitted to Dartmouth, Hitchcock Medical Center in Hanover, New Hampshire, in a study by Shevitz, Silberfarb and Lipowski, as reported in May 1976.⁹

The above findings lend support to what Lipowski said in his article "Consultation—Liaison Psychiatry," in June 1974: "It is in the area of integration of comprehensive health care that the psychiatrist's future role will lie."¹⁰

It is not uncommon for the psychiatrist to pick up physical problems that other doctors have missed, not because the other doctors are not good diagnosticians but because they sometimes get lost in the emotional wastebaskets and fail to remember that psychiatric patients have physical disorders just like other patients.

This leads to giving serious thought to the observation of Horatio Febrege in his article "The Position of Psychiatrists in Understanding Human Disease." He says, "Finally, psychiatrists, like other physicians, had to, and indeed must, treat disease; but how or at what level this treatment takes place should be a critical intellectual concern of the discipline as it is of other medical disciplines."¹¹

Further clarification is found in Arnold M. Ludwig's article, "The Psychiatrist as a Physician." He says, "In my opinion, there can only be one sound

foundation for psychiatry, that based on the medical model, and only one legitimate domain of expertise, that pertaining to mental illness."¹²

According to Ludwig's concept of the medical model the psychiatric physician would then have responsibility for (1) differential diagnosis, (2) establishing diagnosis on the basis of specific symptoms and signs, laboratory tests and knowledge of particular illness, (3) choosing treatment setting and, (4) selecting specific therapists for care of the patient.¹³

The confusing stories and complaints that patients with emotional disorders present to the general physician are sometimes very frustrating and no doubt may lead him or her to feel that little can be done for the patient until the emotional problem is somewhat resolved. Thus, it often falls to the lot of the psychiatrist to unravel the mystery.

Presently physicians in our area have become alert to the above problems so we can depend upon their physical evaluation with the realization that the patient's condition may change at any time.

In Hattiesburg, we have approximately 100 physicians. Ninety per cent are specialists and the remainder are family physicians. We have two hospitals containing approximately 600 beds. One of the hospitals has a 20-bed unlocked psychiatric unit used for psychiatric patients and as an overflow for medical patients when the hospital is crowded.

We have four psychiatrists in private practice on the hospital staff and one psychiatrist associated with the mental health center on the hospital staff. There is one psychiatrist in the area who limits his practice to office work.

We freely ask the other doctors for consultations, but in most cases remain the primary physician, just as we encourage the other doctors to continue as the primary physician when we are called in consultation unless the patient is transferred to the psychiatric unit.

We try to provide a service so that we will see the patients within 24 hours of request for consultation and someone is available 24 hours a day to provide this service.

We try to maintain our physician image in accordance with what Dana L. Farnsworth said in 1971: "Each psychiatrist (who is a physician) should be a physician first and a psychiatrist second. He is to maintain the breadth and balance needed in a profession that has so many variables and orientations."¹⁴

A recent survey in Hattiesburg, showed that our image as psychiatrists and physicians in this area is basically good.

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The following study was done by Barry Haywood, MSW, Forrest General Hospital, Hattiesburg. Almost one-third of the physicians (31) completed a questionnaire and returned it for evaluation.

To help avoid personal loyalties, names were not asked for and personal interviews were not conducted.

PSYCHIATRIC QUESTIONNAIRE

Responses are based on a Scale of 1 to 5

1. Medical Specialty or Health Profession

<u>4</u>	Family Practice	<u>4</u>	Medicine
<u>3</u>	Surgery	<u>1</u>	Nephrology
<u>2</u>	OB/GYN	<u>1</u>	Pathology
<u>0</u>	Pediatrics	<u>1</u>	Adolescent Medicine
<u>4</u>	Ophthalmology	<u>11</u>	Not Specified
		<u>31</u>	Total

2. What is your opinion of psychiatry?

Negative	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Positive
			<u>1</u>	<u>4</u>	<u>5</u>	<u>19</u>

Comments: Making progress (1)

3. What is your opinion of the psychiatrists in this geographical area?

Negative	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Positive
			<u>3</u>	<u>6</u>	<u>20</u>	<u>1</u>

Comments: One respondent responded 3, 4 and 5.

4. Are psychiatric services provided adequately?

No	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Yes
	<u>1</u>	<u>1</u>	<u>7</u>	<u>7</u>	<u>12</u>	<u>3</u>

Comments: Methodist is largely neglected (1) Forrest General outpatient (1): Need varied outpatient group therapy sessions.

5. What is your opinion of inpatient psychiatric consultation services?

Negative	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Positive
		<u>1</u>	<u>2</u>	<u>5</u>	<u>18</u>	<u>3</u>

Comments: No answer (1): Little experience (1)

6. What is your opinion of outpatient psychiatric consultation services?

Negative	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Positive
	<u>1</u>	<u>3</u>	<u>7</u>	<u>7</u>	<u>11</u>	<u>1</u>

Comments: Don't know (1); Difficult for patient to see you when needed; hard to get appointment (7); Delay in getting appointment; Total treatment cost and low ratio seems a barrier to many who need care.

7. Do you feel that the psychiatrist should follow the medical model of being a physician?

No	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Yes
		<u>1</u>	<u>3</u>	<u>2</u>	<u>17</u>	<u>6</u>

Comments: Definitely: What does this mean? (2) Use scientific method.

8. Do you feel that the psychiatrist should handle the medical problems that he is capable of treating, asking

for consultation on the complicated cases?

No	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Yes
	<u>1</u>	<u>2</u>	<u>1</u>	<u>3</u>	<u>19</u>	<u>4</u>

Comments: As he desires (1); Qualified by treating problems that are 1° psychiatric.

9. Do you feel that the psychiatrists are capable diagnosticians to the point of being able to recognize disease and the need for medical consultation?

No	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Yes
	<u>1</u>		<u>4</u>	<u>3</u>	<u>18</u>	<u>5</u>

Comments: At least in this community.

10. Do you feel that the psychiatrists are helpful to you in managing your own patients either by consultation with the patient or consultation with you about your patient?

No	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Yes
		<u>2</u>	<u>2</u>	<u>1</u>	<u>20</u>	<u>6</u>

Comments:

11. Would you like to see the psychiatrists more or less involved in the practice of general medicine?

Less	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	More
	<u>2</u>	<u>4</u>	<u>2</u>	<u>10</u>	<u>3</u>	<u>9</u>

Comments: None

12. Are the psychiatrists helpful to you in better understanding your patient's emotional needs?

No	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	Yes
	<u>1</u>	<u>3</u>	<u>3</u>	<u>4</u>	<u>13</u>	<u>6</u>

Comments: No need so far (1); Sometimes yes, sometimes no.

Although generally favorable, psychiatrists' shortcomings show up in ability to meet the needs of Methodist Hospital and difficulties in finding times to provide all the outpatient services. Addition of staff has helped, but the demands always seem to exceed the available service.

These Hattiesburg survey findings are similar to those of Norman West and Margaret Walsch who did an attitudinal survey in 1975 of the psychiatrist's image in the medical community in a large midwestern section of the country and concluded that the psychiatrist's image was good in that area.²

In conclusion I feel that the psychiatrist has earned a place in the medical community.

There are approximately 28,000 psychiatrists in the United States. Bertram Brown has divided psychiatrists into seven categories. Type one is the neuropsychiatrist, a rapidly vanishing group. Type two is the psychodynamically oriented psychotherapist, a group that is beginning to decline. Type three is the psychoanalyst, another dwindling group. Type four is the biological psychiatrist, a group that is growing and changing the profession as a whole and influencing society. Type five is the child psychiatrist, a working growing group. Type six is the social psychiatrist, the administrative group. Type

H

20
150

E A R

20
100

I N G I S

20
70

20
50 A S P R E C I O U S

20
40 A S S I G H T H A V E

20
30 Y O U H A D Y O U R H E A R I N G

20
20 T E S T E D L A T E L Y A S I M P L Y

20
15 C O M F O R T A B L E H E A R I N G

20
10 I N V E S T M E N T O F A F E W M I N U T E S

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In one long-term study¹ Zaroxolyn brought moderately elevated (average 161/109 mm Hg) blood pressure down to the range of normotension—and held it there for a year or more.

The investigator noted, "Patient cooperation was surprisingly good for a study of such duration [2½ years]. The once-daily dosage schedule with

metolazone [Zaroxolyn] no doubt contributed to patient compliance."

Overall compliance with Zaroxolyn is good—very good. An analysis of controlled clinical studies involving 188 Zaroxolyn patients showed that only eight discontinued therapy because of side effects. That's a discontinuation rate of only 4.3%, and broader clinical experience appears to substantiate this low rate?²

Zaroxolyn. For long-term control and comfortable compliance in mild to moderate hypertension.

Recommended initial dosage in mild to moderate essential hypertension—2½ to 5 mg once daily

Zaroxolyn[®]
(metolazone, Pennwalt)

2½-mg, 5-mg and 10-mg tablets

once-daily antihypertensive diuretic

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma; allergy or sensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing

age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth,

hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg

References:

- 1 Dornfeld L, Kane R. Metolazone in essential hypertension. The long-term clinical efficacy of a new diuretic. *Curr Ther Res* 18: 527-533, 1975
- 2 Data on file, Medical Department, Pennwalt Prescription Products

PENNWALT

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seven is the "experimental or fringe" group using a variety of techniques and often found doing the unusual things in the unusual places.¹⁵

Brown indicated that type seven has the greatest influence on the future of psychiatry.¹⁵ This may well be true, but with the influence of PSRO and third party payment, I feel that the biological psychiatrist will be the busy physician of tomorrow, as this is the group that the public is most likely to accept and that third party payors are most likely to pay for services rendered.

It may be that the role of the psychiatrist under the third party payor systems will be more of a consultant, diagnostician and prescriber of therapies (drug, group therapy, psychotherapy and other services). Economically we may have to see more patients for shorter periods of time and leave the time consuming therapies to the people who can afford to work at a lower pay scale.

Brown says, "I believe that psychiatry faces less danger from adversity than it does from diversity."¹⁶ I certainly agree that there is room in the field of psychiatry for the innovator, but most of us need to be busy practicing our professions as physicians.

In 1972 George Engel said, "in brief, academic psychiatry appears not only to be in full retreat from the hard-won battle to be recognized as a major medical discipline, but even worse, to be abandoning its responsibilities to contribute to the improvement of the quality of the care of the sick through research and education of the physician. This is an ominous trend. Its ultimate outcome could be the discrediting, if not the destruction, of psychiatry as a discipline."¹⁷

In 1974 Richard Schwartz said, "The blurring of roles between psychiatrists and other medical health disciplines and the delegation of responsibility for diagnosis and treatment of the ill to the non-physician cannot help but lead the general medical profession and lay public to regard psychiatric disorders as non-illness and to regard psychiatrists as something other than a physician."¹⁸

Once again we are moving in the right direction as noted at the 1976 APA meeting in Miami Beach as James S. Eaton, James W. Strain, Judd Manor, outgoing president, and Walter Barton have all pointed out evidence suggesting that once again psychiatrists are finding their way back into medicine.

Barton attributes this to the following trend, "(1) The resuming, next year, of a psychiatric internship, heavy on general medicine. (2) The increased use of psychiatrists as consultants through liaison psy-

chiatry. (3) The effective use of drugs, such as the MAO inhibitors for depression and Lithium for mood swing disorders. In the future, he noted, there may even be medications to control schizophrenia. (4) Improvements in biofeedback behavior modification."¹⁹

In conclusion, I feel that the psychiatrist has a license to practice medicine and he should use his training to the fullest. He has a unique claim to a special area of medicine which no other counselor or therapist has and as more emotional problems prove to be of an organic nature, he alone will find his skills more nearly meeting the complete needs of his patients.

We no longer need to feel in competition with psychologists, social workers, guidance counselors, pastoral counselors and other therapists as they each have their own area of expertise. Their failures and difficult cases will often wind up on our shoulders if we insist upon being physicians.

After reading Arthur K. Sharpiron's *Contributions to the History of the Placebo Effect*, I am in agreement that we should use the magic of all therapies to their fullest before they lose their placebo effect, but I remain aware that the physician as a placebo is as strong as ever in the 1970's.²⁰

My plea to psychiatrists is to use whatever therapeutic approach seems to help their patients and that they find themselves qualified to do, keeping in mind that they are primarily physicians. ★★★

405 South 28th Avenue (39401)

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New JOURNAL MSMA policy allows only 10 references to be published. The author will furnish a complete list of references (20) on request.

Radiologic Seminar CLXXI: Metastatic Melanoma and Primary Adenocarcinoma in the Same Breast: A Case Report

REBECCA HARRELL, M.D.

Jackson, Mississippi

METASTATIC DISEASE to the breast is rare.¹ Less than 100 cases have been reported in the literature. However, no previous case report of simultaneous metastatic and primary tumor in a breast was found.

On Oct. 1, 1976, a 63-year-old female was admitted to the University Medical Center for chemotherapy for malignant melanoma.

A mole on the lateral, posterior aspect of her left upper arm had grown slowly for four years and then rapidly for two or three months. The mole was removed on July 16, 1976, and the diagnosis of melanoma was made. On July 20, 1976, a wide excision with skin grafting and axillary node dissection was done. Seventeen nodes were negative.

On admission on Oct. 1, 1976, physical examination revealed a small mass in the lower, outer quadrant of the left breast.

Mammograms on Oct. 5, 1976, were interpreted as demonstrating two masses: "A small, spiculated mass in the superolateral left breast is consistent with carcinoma. A 1 cm. fairly well-circumscribed mass in the inferolateral left breast, which is palpable, is probably benign" (see Figure 1a and 1b).

Since the small mass which was interpreted as carcinoma was not palpable, it was localized with needles in the Radiology Department before excision on Oct. 12, 1976 (see Figure 2a and 2b). The nodule was an infiltrating ductal carcinoma. On Oct. 14, 1976, a left simple mastectomy showed no residual primary tumor. However, the 1 cm. mass seen on the mammogram and another tiny nodule not seen grossly were metastatic melanoma.

The patient will soon begin her seventh course of systemic chemotherapy.

Virchow (1863) noticed that almost all organs which show a strong tendency to develop primary

malignant disease are seldom the site of secondary deposits. The paucity of cases of metastatic disease to the breast has been attributed to the fact that at the time when malignant disease is common in women, the breast is no longer a suitable organ for deposits to grow (because of large areas of fibrous tissue and a relatively poor blood supply).² Others



Figure 1(a)

Figure 1. Mammograms. (a) Mediolateral View. The small spiculated mass superiorly was carcinoma. The well-circumscribed mass inferiorly was metastatic melanoma. (b) Craniocaudal View.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University Hospital,
Jackson, MS.



Figure 1(b)

have explained the metastases as a result of a hormone imbalance produced with a large dose of estrogen.³ There seems to be a higher incidence in men receiving estrogen therapy for carcinoma of the prostate.

The most common primary sites which metastasize to the breast have been given as follows:

1. Carcinoma from the opposite breast.
2. Leukemia, lymphoma, and other members of the so-called multicentric group of malignancies.
3. Widely disseminated malignant melanoma in its terminal stage.
4. Carcinoma of various organs other than breast; stomach and ovary in particular.
5. Carcinoma of the prostate in patients receiving estrogen therapy.⁴

Charache claims that metastatic tumors in the breast are less fixed to the surrounding tissues than primary growths and may often be freely movable.⁵ In particular, there is a report of metastatic melanoma in the breast masquerading as fibroadenoma.¹ However, there are two case reports of metastatic disease presenting as inflammatory carcinoma. Ovarian carcinoma metastases to the breast presented in

this way with erythema, increased temperature, and peau d'orange of the peri-areolar skin.⁴ Also a gastric carcinoma metastatic to the breast presented as bilateral inflammatory carcinomas.⁶

Unfortunately, most of the cases reported do not have radiographic evaluation of the breasts. In the case of gastric carcinoma metastases presenting as bilateral inflammatory carcinomas, mammograms were interpreted as bilateral inflammatory carcinomas.⁶ In two cases of ovarian papillary cystadenocarcinoma, metastases to the breasts contained calcifications.^{7,8} There have been several cases of metastatic melanoma appearing as well-circumscribed masses on x-ray, indistinguishable from benign fibroadenoma.¹ The case presented here is similar.

The prognosis in metastatic breast disease is poor. One report states that most patients die within six months from the appearance of the breast lesion.⁴ Mastectomy has not altered the course. Simple excision is recommended for diagnosis and for patient comfort; then systemic chemotherapy.⁹



Figure 2(a)

Figure 2. (a) Mediolateral View. (b) Craniocaudal View. A small needle localizes the carcinoma which was not clinically palpable. (See next page for Figure 2b.)



Figure 2(b)

Summary

A case report of simultaneous primary adenocarcinoma and metastatic melanoma in the same breast is presented. Metastatic disease to the breast is rare. A review of the literature, which includes the most common primary sites of tumor, characteristics of metastatic breast disease, and recommended treatment, is given. ★★★

2500 North State Street (39216)

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SOCIAL SECURITY RED INK

Old-Age, Survivors and Disability Funds by Calendar Year—

	<i>Income</i>	<i>Outgo</i>	<i>Surplus or Deficit (-)</i>
1971	\$ 40.9 billion	\$ 38.5 billion	\$2.4 billion
1972	45.6 billion	43.3 billion	2.3 billion
1973	54.8 billion	53.1 billion	1.6 billion
1974	62.1 billion	60.6 billion	1.5 billion
1975	67.6 billion	69.2 billion	-1.5 billion
1976	73.8 billion	78.2 billion	-4.3 billion
1977	83.0 billion	86.9 billion	-3.9 billion
1978	91.6 billion	96.8 billion	-5.2 billion
1979	109.9 billion	106.9 billion	-5.9 billion
1980	110.6 billion	117.8 billion	-7.2 billion
1981	120.6 billion	129.2 billion	-8.6 billion

Counsel to Authors

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly),

and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

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The President Speaking

In Unity and Purpose

JAMES O. GILMORE, M.D.
Oxford, Mississippi

IN UNITY AND calmness of serious purpose, few annual meetings of our association have exceeded the recent 109th Annual Session.

More than 850 physicians, their wives and guests registered for the meeting, a new attendance record for the Coast. Many important matters were on the agenda of the House of Delegates including a dues increase, the Governor's illegal appointments to the State Board of Health, organization of the Mississippi Medical Fraternal and Educational Society and other subjects. All are reported elsewhere in this issue of the JOURNAL.

Each item was considered carefully and I believe more thoroughly than at past annual meetings because this year all reports to the House of Delegates were mailed to Delegates two weeks prior to the meeting.

Perhaps the 1976-77 president of our association, Dr. Lyne S. Gamble, best described the climate for the 109th Annual Session when he stated in his address to the House of Delegates—"This has been an eventful year. On the national scene a new administration has taken office dedicated to a national health insurance plan. Here at home we find ourselves being sued for following a law that has been adhered to by every administration in this state since the law was passed in 1926."

I believe one of the most important matters before us during my first few weeks in office will be the question of whether to organize the Mississippi Medical Fraternal and Educational Society as an alternative to the worsening professional liability insurance market.

As reported to the House of Delegates, there is now only one carrier writing new coverage in our state. That coverage is on a "claims made" policy which has increased some 100 per cent in cost over the last two years and is now projected to increase almost 400 per cent during the first five years of coverage under the policy. The "reporting endorsement" for the claims made policy to cover claims incurred but not reported at time of retirement was recently priced to a Jackson physician at \$6,000.

Mailings are going out to the membership concerning the society and its purpose. Our officers and staff stand ready to arrange meetings with local hospital staffs and component societies to discuss the society. This matter deserves our careful and immediate attention.

I look forward to my year as your 1977-78 president. I have some big footsteps to follow, but with your understanding and assistance I know this can be an outstanding year for our professional association. ★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XVIII, NUMBER 6

JUNE 1977

Equal Rights—Equal Pay

At the 108th Annual Session a resolution was considered asking that our delegates to the AMA again attempt to obtain assistance and direction from that body in helping equalize Medicare payments throughout Mississippi. This action, sponsored by the local society from the area served by the lowest paying scale in the nation, originally asked that portions of the AMA dues from Mississippi members be withheld until such action was accomplished.

While every possible avenue should be explored in attempting to correct this problem such action must be discrete, well placed, totally supported by the membership, and taken only after much preparation.

South Carolina had the same problem as Mississippi, being separated into three areas, rural, urban, and metropolitan, with wide variations in reimbursement for equal services. Attempting to overcome this inequity, the South Carolina Medical Association supported and secured passage of a state bill asking that geographic differentiation be abolished, with equal third party payments to all physicians for equal services. In response, the Department of Health, Education and Welfare interpreted this action as a request from the people of South Carolina that all physicians be paid on the lowest, or rural, scale. Thus since July 1976, this has prevailed. Several alternative actions have been proposed by the South Carolina Medical Association, all with sacrifices by virtually all physicians of that state.

This action exemplifies bureaucratic thinking and reaction. In many instances a feeling of vindictiveness is present. Our association must continue in its efforts to have these inequities corrected, yet in doing so must be ready to deal with a difficult team. Why the taxpayer, paying the same rates in Mississippi as in other states, must be served by a different and lower scale is difficult to understand. Even more difficult to understand is why Mississippi should be sub-

divided. Surely there is little difference in the practice of medicine in the various areas of our state.

MYRON W. LOCKEY, M.D.
Associate Editor

Medico-Legal Brief

Physician Loses Suit Against Patient and Attorney

A physician had no cause of action for constructive contempt against a patient and an attorney who filed an allegedly groundless malpractice suit against him, a Texas appellate court ruled.

The patient filed suit against the physician, alleging negligence in failing to diagnose and properly treat injuries he suffered in an accident. A jury returned a summary judgment in favor of the physician.

A few months later, the physician filed a suit against the patient and his attorney. He alleged that they knew or should have known that no cause of action existed against him and that they made allegations that they knew or should have known were untrue. The physician claimed that he suffered mental trauma which required treatment by a psychiatrist and which prevented him from performing his duties as an orthopedic surgeon. He sought \$750,000 in damages for embarrassment and for probable loss of future earnings. A trial court concluded that no such cause of action existed under Texas law.

On appeal, the appellate court said that the physician did not assert a cause of action for constructive contempt because there was no allegation that the patient violated a court order.

The malpractice suit did not invade the physician's privacy, either, the court added. Communications in judicial proceedings are absolutely privileged, the court said, and are immune from actions for invasion of privacy.

The court affirmed the trial court's judgment.—*Wolfe v. Arroyo*, 543 S.W.2d 11 (Tex.Ct. of Civil App., Oct 13, 1976)

PERSONALS

THOMASINA BLISSARD of Jackson was presented an Alumna of the Year award by Belhaven College at Homecoming activities in Jackson.

HUGH P. BROWN of Jackson was inducted into the American Academy of Orthopaedic Surgeons at Las Vegas in February. He was also inducted as a member of the American Academy of Cerebral Palsy and Developmental Medicine.

RICHARD E. BUCKLEY of Biloxi has been elected Chief of Staff of the Medical Executive Board at Gulf Coast Community Hospital. Other members elected to the executive board are MORTON LONG-NECKER, chief of staff-elect; ROBERT MIDDLETON, JR., secretary-treasurer; MAX CURRY, chief of medicine; and CLYDE HAGOOD, chief of surgery.

JOHN F. BUSEY of Jackson was elected 1st vice president of the Mississippi Lung Association at the MLA annual meeting in Jackson. Other physicians serving on the Board of Directors to implement year-round programs of prevention and control of lung diseases are GUY CAMPBELL, ALTON COBB, ROLAND B. ROBERTSON, CLYDE WATKINS, all of Jackson, MARIAN GODBEY of Aberdeen and ROBERT E. SCHWARTZ of Hattiesburg.

FRANK B. COLLINS announces the opening of his practice of general, thoracic and cardiovascular surgery at 408 S. 25th Avenue in Hattiesburg.

REX W. COLLINS of Laurel and JOSEPH E. VARNER of Hattiesburg are recent enrollees in the Medical Alumni Guardian Society of the University of Mississippi Foundation.

ROGER P. COOK has set up his practice of ear, nose and throat, nasal reconstructive and micro ear surgery at 100 North Main Street in Iuka.

EVERETT CRAWFORD and JAMES J. PITTMAN of Tylertown were awarded the Service to Humanity Award by Mississippi College for their contributions in the field of medicine and to the community.

WILLIAM GARY GILES and GEORGE E. WILKERSON of Hattiesburg were on the program for the annual hospital conference for ministers held recently at Forrest General Hospital.

M. E. HINMAN of Vicksburg is coordinating events for the 1977-78 Vicksburg Community Concert Association.

C. A. HOLLINGSHEAD, M. R. CASEY, and J. P. BALASKI of Laurel have changed the name of their clinic to The Laurel Family Clinic. Offices are located at 103 S. 12th Avenue.

EDWARD D. JOHNSON, JR., has associated with the Hattiesburg Clinic Professional Association for the practice of family medicine at 415 S. 28th Avenue.

T. D. LAMPTON of Jackson has been named a director of the Lampton Company in Columbia.

DEWEY H. LANE of Pascagoula was honored as the Mississippi Economic Council's outgoing president at the annual meeting in Jackson in April.

WILLIAM A. LONG, JR., and J. M. MONTALVO of Jackson were guest speakers at the spring meeting of the American Academy of Pediatrics in New Orleans.

JAMES C. MATTHEWS of Meridian has been inducted as a fellow of the American College of Surgeons.

J. S. MCILWAIN announces the relocation of his office to 901 Hwy. 80 East in Clinton.

JAMES E. MORNEAU has associated with JACK D. DANIEL and RICHARD A. JOHNSON of Hattiesburg for the practice of urology and urological surgery at the Hattiesburg Urology Clinic, P.A., 2802 Mamie Street.

VERONICA M. PENNINGTON of Jackson was invited by the American Psychiatric Association to receive an honor at the Toronto annual meeting of the APA, May 1-5.

BILL PETERS has associated with DAVID H. STRONG of Brookhaven for the practice of family medicine at 1020 Biglane Drive.


JAMES PITTMAN of Laurel devised and designed a special needle holder which Parke Davis now markets as the Pittman seven inch curved, needle holder with diamond jaws.

THOMAS G. PUCKETT, Hattiesburg pathologist, spoke on the problems and solutions of the blood bank of the Hattiesburg Clinical Society at the April meeting of the Hattiesburg Medical Auxiliary.

H. DAVIS DEAR, JAMES L. CROSTHWAIT and HENRY B. TYLER of Jackson were guest speakers at the Clarksdale and Six Counties Medical Society meeting.

WAYMOND L. RONE of Jackson has been named a fellow of the American College of Radiology.

JERRY SHEFFIELD has set up his practice of obstetrics and gynecology on Highway 25 in Fulton.



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Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

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Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.


Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes (see Warnings).

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyper-

kalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia,

thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

Guest speakers for the Mississippi Heart Association's 26th annual meeting in Biloxi were MCKAMY SMITH of Jackson and BEN CARMICHAEL of Hattiesburg.

WENDELL H. STOCKTON of Amory was honored with a dinner by local doctors and members of Gilmore Memorial Hospital Board of Directors.

THOMAS L. SWEAT of Corinth has been elected president-elect of the Mid-South Medical Association.

DOMINIC TUMMINELLO of Cleveland was honored at a reception at the Knights of Columbus Hall given by the staff of the Bolivar County Health Department. He was presented an Accutron watch on occasion of his retirement.

FOREST TUTOR of Tupelo ran in the recent 81st Boston Marathon.

WILLIAM CHARLES WARNER of Jackson is Mississippi State University's Alumnus of the Year.

W. LAMAR WEEMS of Jackson and UMC was on the guest faculty at the 23rd annual Urology Seminar sponsored by the University of Missouri in Kansas City.

TERRY WESTBROOK of McComb announces the relocation of his office to the Medical Arts Building, 300 Rawls Drive.

JOHN R. WILLIAMS, JR., of Greenville was on the guest faculty for the Mississippi Thoracic Society annual meeting in Jackson.

POSTGRADUATE CALENDAR

June 8, 1977

FAMILY PRACTICE PRECEPTOR WORKSHOP
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Family Medicine and Medical Center Division of Continuing Health Professional Education, with grant funds from the Department of Health, Education and Welfare.

Coordinators: Robert Smith, M.D., and Thomas M. Davis, M.D., clinical instructors of family medicine, University of Mississippi School of Medicine Department of Family Medicine.

This one day course is for family physicians who

will serve as preceptors to teach medical students at the community level. Each participant will have a UMC medical student as a member of his health care team for a three-week period during the school year. There is no fee for the course.

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

DEATHS



AYCOCK, WILLIAM JASPER, Calhoun City. M.D., Memphis Hospital and Medical College, Memphis, TN, 1912; member of Fifty Year Club of MSMA; Emeritus member of MSMA and AMA; died April 18, 1977, age 88.

DAVIDSON, DAVID EUGENE, Whitfield. M.D., University of Tennessee School of Medicine, Memphis, 1941; interned Mobile City Hospital, Mobile, AL, one year; psychiatry residency, Riverside County Hospital, Arlington, CA, Feb. 1946-June 1947; died May 6, 1977, age 60.

LETTERS

SIRS: I am convinced that lives now needlessly lost to severe systemic reactions to insect sting could be saved by a greater awareness of both the possibilities of such fatal responses and of the existence of insect sting kits to be employed as emergency, first aid measures to stave off anaphylaxis. Because of this conviction, I am in the process of collecting and collating data on the incidence of such fatalities. I am especially interested in the time lapse between sting and death, although other information would also be greatly appreciated such as the following: time sequence of symptoms, previous reactions victim may have had to insect stings, whether and what medication the victim may have had on hand at the time of the incident, the type of insect if known, how many stings the victim may have suffered, and an estimation of whether or not a physician or hospital emergency room could have been reached in time to avoid a fatal outcome.

CLAUDE A. FRAZIER, M.D.
4-C Doctors Park
Asheville, NC 28801

LETTERS / Continued

SIRS: In reference to new criteria listed for brain death in the April issue of the JOURNAL OF MSMA, the article states in the second criteria that the brain is completely unresponsive, breathing without the machine is stopped, pupils are dilated, reflexes such as blinking are missing, and the electrocardiogram is silent for 30 minutes to at least six hours after the stroke or accident.

I believe it has been standard policy for many years that if the electrocardiogram is flat the patient is pronounced dead. I wonder if this is not a typographical error or an error somewhere along the line that this does not refer to electroencephalogram.

RALPH THOMAS WICKER, M.D.
Chief, Neurosurgery
Forrest County General Hospital
Hattiesburg, MS

Ed. Note: Dr. Wicker is correct. The *JAMA* article (on p. 982-986, March 7, 1977) criteria lists electrocerebral silence as determined by interpretation of the EEG. JOURNAL MSMA's article was taken from the above. The JOURNAL regrets the typographical error and appreciates Dr. Wicker's taking time to write so that the matter can be set straight.

NEW MEMBERS

BEALL, JON MICHAEL, Jackson. Born Philadelphia, MS, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1972; internship and residency in medicine, University Medical Center, Jackson, 1972-76; elected by Central Medical Society.

BRASFIELD, DANIEL L., Tupelo. Born Tupelo, MS, 1942; M.D., Washington University School of Medicine, St. Louis, MO, 1968; interned Charity Hospital, New Orleans, LA, one year; radiology residency, Vanderbilt Hospital, Nashville, TN, 1972-75; elected by Northeast Mississippi Medical Society.

BRYANT, THOMAS R., Jackson. Born Verona, MS, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned Spartanburg General Hospital, Spartanburg, SC; elected by Central Medical Society.

CORNELIUS, LELAND R., Southaven. Born Chattanooga, TN, 1928; M.D., University of Tennessee College of Medicine, Memphis, 1963; interned Baroness Erlanger Hospital, Chattanooga, TN, one year; elected by Desoto County Medical Society.

CRAWFORD, FRED A., JR., Jackson. Born Columbia, SC, 1942; M.D., Duke University School of Medicine, Durham, NC, 1967; interned Duke University, Durham, one year; surgery and cardiovascular residency, same, 1968-69 and 1971-76; elected by Central Medical Society.

CRENSHAW, CHARLES N., JR., Newton. Born Tchula, MS, 1929; M.D., University of Mississippi School of Medicine, Jackson, 1961; interned Baptist Hospital, Jackson, one year; elected by East Mississippi Medical Society.

EAST, WILLIAM W., JR., Meridian. Born Meridian, MS, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned University Hospital, Jackson, one year; ophthalmology residency, University of Miami, Miami, FL, 1970-74; elected by East Mississippi Medical Society.

EMERSON, CHARLES W., JR., Jackson. Born Hernando, MS, 1935; M.D., University of Tennessee College of Medicine, Memphis, 1959; interned Duval Medical Center, Jacksonville, FL, one year; surgery residency, Baptist Memorial Hospital, Memphis, TN, 1961-62 and 1964-66; orthopedic surgery residency, Ben Taub General Hospital, Houston, TX, 1966-67; fellowship, hand surgery, Roosevelt Hospital, NY, 1967-68; elected by Central Medical Society.

HERNDON, CALEB W., Brookhaven. Born Lubbock, TX, 1943; M.D., Tulane University School of Medicine, New Orleans, LA, 1971; interned USPHS, New Orleans, LA, 1972-73; ophthalmology residency, same, 1973-76; elected by South Central Medical Society.

IRWIN, ROBERT J., JR., Jackson. Born Cleveland, OH, 1941; M.D., Harvard Medical School, Boston, MA, 1967; interned Massachusetts General Hospital, Boston, 1968-68; surgery residency, same, 1968-69; urology residency, same, 1971-74; elected by Central Medical Society.

JARRETT, ROBERT W., Meridian. Born Murfreesboro, TN, 1940; M.D., University of Tennessee School of Medicine, Memphis, 1969; interned Baptist Hospital, Memphis, TN, 1969-70; pathology residency, same, 1970-73; fellowship, same, 1973-74; elected by East Mississippi Medical Society.

MASON, WOODIE LYNN, Jackson. Born Pascagoula, MS, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Mobile General Hospital, Mobile, AL, 1969-70; urology residency, University Medical Center, Jackson, 1970-74; elected by Central Medical Society.

ROBBINS, JAMES S., Greenwood. Born Mayfield, KY, 1944; M.D., University of Tennessee School of Medicine, Memphis, 1969; interned Beaumont Army Hospital, El Paso, TX, 1970-71; urology residency, Walter Reed Army Medical Center, Washington, DC, 1971-75; elected by Delta Medical Society.

SHIPP, BERNARD L., CORINTH. Born Rome, MS, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned Parkland Memorial Hospital, Dallas, TX, one year; ophthalmology residency, University of Alabama Eye Foundation Hospital, 1973-76; elected by Northeast Mississippi Medical Society.

WILCOX, W. PAUL, Meridian. Born Auburn, NY, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Bowman Gray, Winston-Salem, NC, 1969-70; fellowship in critical care medicine, same, 1974-75; elected by East Mississippi Medical Society.

YOUNG, WILLIAM D., Waynesboro. Born Texarkana, AR, 1937; M.D., University of Mississippi School of Medicine, Jackson, 1962; interned Oakland Naval Hospital, Oakland, CA, one year; general surgery residency, same, 1964-68; elected by South Mississippi Medical Society.

UMC Student, Professors of the Year Are Recognized

A Hattiesburg medical student and two University of Mississippi Medical Center faculty members were recognized during the annual meeting of the Mississippi State Medical Association last month.

The University of Mississippi Medical Alumni Chapter presented George Edward McGee of Hattiesburg the Student of the Year Award. Classmates elected McGee, a senior, for the honor.

Students also selected the Clinical and Preclinical Professors of the Year, each of whom received \$500 awards given by the alumni chapter.

Seniors elected Dr. Mac Andrew Greganti, assistant professor of medicine, as the clinical professor, and sophomores named Dr. Dennis John O'Callaghan, associate professor of microbiology, as the pre-clinical choice.

University Hospital Elects Medical Staff

The current vice-chief of staff for University Hospital, Dr. Robert D. Currier, will become chief of staff for the 1977-1978 term beginning July 1. Dr. Currier is UMC professor of medicine.

Other officers elected at the semi-annual meeting in April were Dr. John F. Jackson, professor of preventive medicine, vice-chief of staff; Dr. Patricia Moynihan, associate professor of surgery, secretary; and Dr. June C. Blount, assistant professor of radiology; Dr. Michael E. Jabaley, professor of surgery, and Dr. Francis Morrison, professor of medicine, executive committee members.

UMC Students Receive Honors and Awards

Medical and graduate students at the University of Mississippi Medical Center were recognized during the 16th annual UMC School of Medicine Honors Day last month.

Dr. William H. Sweet, chief of neurosurgery at Massachusetts General Hospital and emeritus professor of surgery at Harvard Medical School, was guest speaker for the honors day program and the Alpha Omega Alpha banquet.

The Upjohn Award for the highest academic average for three years went to William Arthur Schmid, Jr., of Jackson who also captured the J. Robert Snively Award for outstanding performance in medicine in the junior and senior years. Schmid was also recognized as the recipient of the John C. and Nina A. Culley Memorial scholarship, awarded to top pre-medical students at the University of Mississippi.

James Ewell McDonald of Clinton received the Sandoz Award for the junior with the highest academic average at the end of two years of medical school.

James Robert Haltom of Natchez received the Raymond A. Alford Memorial Award for the highest academic average as a freshman, and classmates selected Nancy Karen Hutchinson of Baton Rouge, LA, as recipient of the CIBA Award for outstanding community service.

The Dr. Elise Rutledge Prize went to Connic Smith McCaa of Jackson as the third-year student with the highest evaluation in surgery. Dr. McCaa also received a Louisiana-Mississippi Ophthalmological-Otolaryngological Award along with Michael Richard Ursic of Oxford, Camille Jeffcoat of Jackson, and Harmon Sidney Prosser of Vicksburg.

William Timothy Denton of Pope and Rafel Dwaine Rieves of Smithville received the Ernest W. Goodpasture Award for superior performance in pathology.

Graduate students Cheryl Lane Smith Hardy of Jackson and Robert Edwin Lewis, Jr., of Meridian were presented the Robert A. Mahaffey, Jr., Memorial Award as outstanding Ph.D. candidates.

Daniel Neil Granger of Erath, LA, received the Sigma Xi award for meritorious research.

First recipient of the Pennington Award was Nancy Lee Childs of Great Bend, KA, for an outstanding clinical and academic record in psychiatry.

The Daryl Douglas Memorial for the sophomore student "who most consistently demonstrates readiness to serve and assist classmates in the pursuit of medical knowledge and skills" went to Craig Allen Dawkins of Leesburg, FL.

Senior Book Awards went to Steven Lee Akins of Pontotoc, Paul Chris Christu of Clinton, George Edward McGee of Hattiesburg, William Arthur Schmid, Jr., of Jackson, David Ronald Segrest of Port Gibson, Newell Bruce Robinson of Columbus, Michael Richard Ursic of Oxford, Thomas Lamar Wiley, Jr., of Tupelo, Jonson Huang, of Troy, MI, and David Clark McMurray of Pascagoula.

Akins was also recognized as recipient of the Mariabel Barber scholarship award.

Junior book award recipients were James Ewell McDonald of Clinton and Walton Lewis Moore of Booneville. Sophomore book award winners were Harrell Edward Cox of Jackson and James Robert Haltom of Natchez. Freshmen recognized as recipients of the awards were Richman Laverne Alexander, III, of Laurel and Hollis Daniel Tidmore of Jackson.

Paul Chris Christu of Clinton, David Ronald Segrest of Port Gibson, Thomas Lamar Wiley, Jr., of Tupelo, John Phillip Foster of Houston, Walton Lewis Moore of Booneville, Grayson Swayze Norquist of Yazoo City, and Edward Eugene Rigdon of Heidelberg were recognized as recipients of John Houston Wear Foundation scholarships, awarded to students at the end of their sophomore year and continued for two years as long as they maintain academic excellence.

THE LITERATURE

Book Review

Basic and Clinical Immunology. Edited by H. Hugh Fudenberg, M.D., Daniel P. Stites, M.D., Joseph L. Caldwell, M.D. and J. Vivian Wells, M.D. 653 pages with illustrations. Los Altos: Lange Medical Publications, 1976. \$12.50.

This latest addition to the Lange *Concise Medical Library for Practitioner and Student* represents one of the better volumes in the series. The purpose of the volume as defined by the editors is to develop an

up-to-date text covering a complex and rapidly changing field of medicine. To accomplish this, the editors have brought together 40 authorities in the field of immunology. These authors have dealt with the subject matter in 4 major sections: immunochemistry and cellular immunology, immunobiology, immunologic laboratory tests, and clinical immunology.

The first section dealing with immunochemistry and cellular immunology is surprisingly detailed for a publication of this nature. Topics covered extend from basic information about immunoglobulins to details of knowledge about immunocompetent cells and their interactions. Certain chapters are not written as clearly as they might have been, the chapter on T and B cell cooperation being most notable in this respect. The overall quality of content is, however, good.

The second section on immunobiology proposes to serve as a bridge between basic immunochemistry and clinical immunology. In this regard, the section is well done. The chapter on "Immune Mechanisms in Tissue Damage" is particularly helpful to the clinician in clarifying some basic concepts of immunologic disease. As an oncologist, I found the chapter on "Tumor Immunology" to be well done.

Section III deals with immunologic testing and describes in concise fashion an array of tests which can be quite confusing to the clinician. Although not as detailed as would be preferred by the specialist in immunologic disorders, the section meets the needs of the student and practitioner adequately.

The last section of the volume covers clinical aspects of immunologic diseases. Though the quality of discussion is variable as is the case with any multiauthored text, this section meets the overall purpose which is, according to the editors, to discuss concepts of disease rather than to serve as a "manual of clinical treatment." It should be noted in particular that the final chapter in this section, "Experimental Aspects of Immunotherapy," is a reasonable summary of efforts to date in the area of immunostimulation of the cancer patient.

In summary, this volume represents an excellent, up-to-date text in the field of immunology. Of particular interest is the editors' promise to produce biennial editions of the text to serve as up-to-date volumes in a complex and changing field. The remarkably low price of \$12.50 will enable the interested physician to maintain a well-done reference in immunology as a part of his medical library.

J. TATE THIGPEN, M.D.
Jackson, MS

Dr. James O. Gilmore Is Inaugurated President, Dr. Carl G. Evers Is Named President-elect

Dr. Carl G. Evers of Jackson was named president-elect of the association at the closing meeting of the 109th Annual Session, and Dr. James O. Gilmore of Oxford was inaugurated 1977-78 president, succeeding Dr. Lyne S. Gamble of Greenville.

The five-day meet was headquartered at the Sheraton-Biloxi and featured meetings of the 12 scientific sections, meetings of more than 15 specialty societies, and medical alumni and social occasions. More than 30 essayists presented a varied program which drew praise of registrants.

The registration had a record high for the Coast of 883 which included 408 members; 37 physician guests; 5 residents, interns and medical students; 41 non-physician guests; 171 exhibitors; 208 Auxiliary members; and 13 staff and press.

Handling a heavy business agenda, the House of Delegates acted on 16 reports, 7 of which were from the Board of Trustees, and 8 resolutions. Three reference committees conducted hearings before which members and guests appeared for discussion and debate. On Monday afternoon, the Mississippi Foundation for Medical Care held its annual meeting.

The president, Dr. Lyne S. Gamble, was unable to attend the annual due to illness so his son, Dr. Hugh Gamble of Jackson, was permitted to read his father's address at the opening meeting of the House of Delegates on May 2. The 1976-77 president dis-

cussed the events of last year including the chiropractic suit, the State Board of Health appointments and the allied health groups' attempts to get laws passed to allow them to diagnose and treat disease. He stated, "The greatest improvements in the health of our people and the largest abatement of health care costs can come from improved individual understanding and responsibility for their health." Dr. Gamble urged MSMA members to carefully consider the matter of establishing a continuing education plan for the association.

The House of Delegates commended Dr. Lyne S. Gamble for his outstanding work as 1976-77 president of MSMA.



Members of the House of Delegates mark ballots to elect new officers of the association.



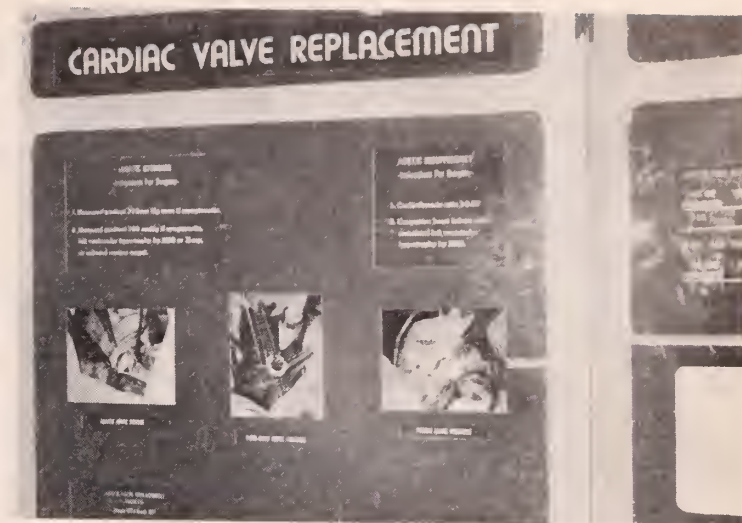
Dr. Richard E. Palmer of Alexandria, Va., president of the American Medical Association, addressed the Monday session of the House of Delegates.



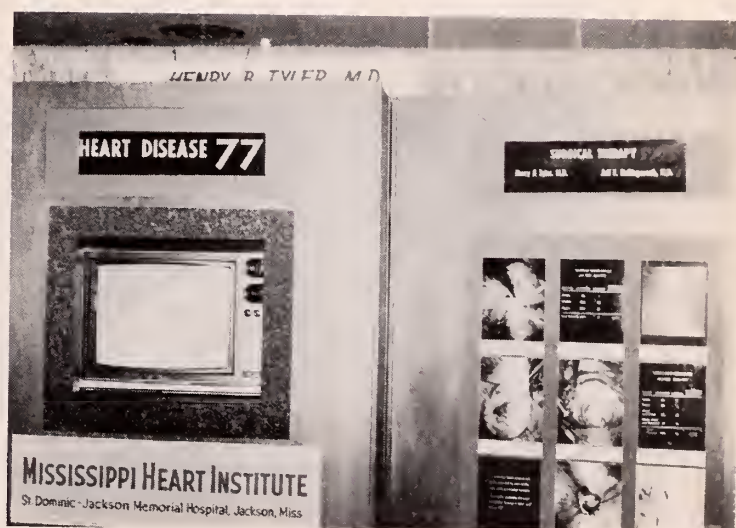
Upper left, members of the reference committees were briefed on their duties during a breakfast meeting on May 2. Speaker C. D. Taylor of Pass Christian and Vice Speaker Faser Triplett of Jackson conducted the session. Lower left, the Council on Constitution and By-Laws debated the resolutions and reports referred to it with interested members of the association present for the discussion. Lower right, the Reference Committee on Reports of Officers, Board of Trustees and Councils also heard members speak on various reports and resolutions referred to it. At right, reference committee chairmen report to the House of Delegates. Dr. J. Elmer Nix of Jackson, chairman of the Reference Committee on Credentials, gives the official attendance. Dr. Virginia Tolbert of Ruleville, chairman of the Reference Committee on Reports of Officers, Board of Trustees and Councils, gives the lengthy report of that committee. Dr. W. Lamar Weems of Jackson, chairman of the Council on Constitution and By-Laws, reports to the House on the items referred to the council.



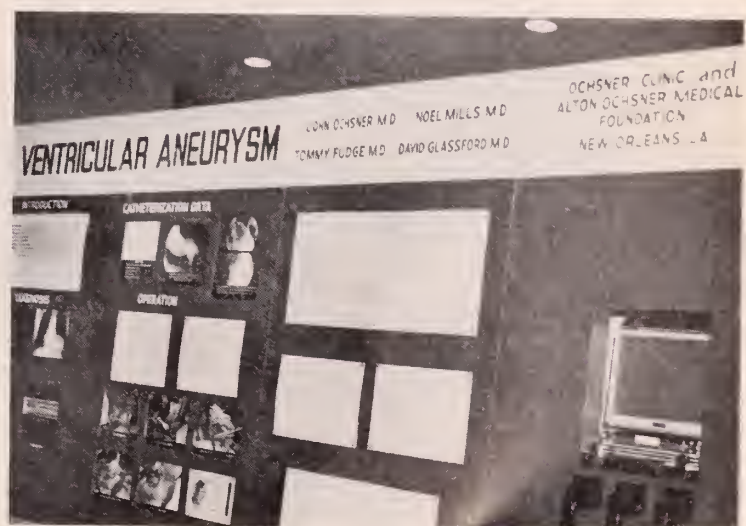
Winners of the MSMA scientific exhibit competition for the 109th Annual Session are shown at right. Upper photo, "Cardiac Valve Replacement" by Drs. Martin H. McMullan and Thomas L. Kilgore of the Mississippi Baptist Medical Center in Jackson won the first place Aesculapins award for best presentation by a member of the association.



"Acquired Heart Disease—Diagnostic Methods and Surgical Therapy" by Drs. James L. Crosthwait, Quinton H. Dickerson, James C. Hays, Jeff F. Hollingsworth, W. Arthur Jones, George K. McMullan, W. H. Rosenblatt, and Henry B. Tyler of St. Dominic Jackson Memorial Hospital won the second place Aesculapins award.



Winning the best exhibit by a nonmember citation was "Ventricular Aneurysm," by Drs. John L. Ochsner, Noel L. Mills, Tommy Fudge and David Glassford of Ochsner Clinic in New Orleans.





Members of the Fifty Year Club participated in their annual luncheon meeting during the annual session. Club "officers" are Board chairman, Dr. Robert S. Caldwell of Tupelo, and MSMA Membership Director Barbara Shelton, who serves as secretary. Presiding in Dr. Caldwell's absence was Dr. Arthur A. Derrick, Jr., of Durant, member of the MSMA Board of Trustees.



Past presidents of the association enjoy a fraternal and traditional breakfast. Immediate past president, Dr. Jack A. Atkinson of Brookhaven, was host.



Shown above are officers of MSMA and the component societies who enjoyed their second annual breakfast meeting to discuss the relationship of the association to the component societies.

Also in the rostrum spotlight was Dr. Richard E. Palmer of Alexandria, Va., president of the American Medical Association, who discussed the activities of the AMA including the national health insurance proposal before Congress.

A gift of \$13,452.20 was made to the University Medical Center by the state association, medical alumni and the MSMA Auxiliary AMA-ERF campaigns.

Vice presidents named to serve during 1977-78 are Drs. Matthew J. Page of Greenville for the northern area, Joe M. Ross, Jr., of Vicksburg for the midstate area, and David M. Owen of Hattiesburg for the southern area.

Dr. Myron W. Lockey of Jackson was named to another two-year term as associate editor of the JOURNAL MSMA.

Dr. G. Swink Hicks of Natchez was re-elected as delegate to AMA and Dr. Stanley A. Hill of Corinth was re-elected to a two-year term as alternate delegate to AMA.

Delegates, tallied at 116 in the May 5 balloting, elected Dr. Ellis Moffitt of Jackson as trustee for District 5. Re-elected to the Board were Drs. Arthur Derrick of Durant (District 4) and Joe S. Covington of Meridian (District 6).

Re-elected to the Council on Budget and Finance was Dr. Gerald P. Gable of Hattiesburg. To serve another term on the Council on Constitution and By-Laws is Dr. W. Lamar Weems of Jackson.

Drs. Gerald A. Smith of Sumner, Wayne T. Lamar of Oxford, and Bruce E. Atkinson of Amory were elected to the Judicial Council.

Elected to serve three-year terms on the Council on Legislation were Drs. Walter H. Rose of Indianola, James W. Rayner of Oxford, and Richard H. Russell of New Albany.

Drs. D. Stanley Hartness of Kosciusko, W. R. Gillis of Jackson, and William M. Hilbun of Meridian were elected to the Council on Medical Education.

Elected to the Council on Medical Service were Drs. William B. Hunt of Grenada, George Ball of Jackson, and Austin P. Boggan of Decatur.

The five-day annual meeting was approved for 14 hours of credit toward continuing education requirements of the American Academy of Family Physicians and the AMA's Physician Recognition Award.

Mrs. William M. Hilbun, Jr., of Meridian was inaugurated president of the Auxiliary in their concurrent annual meeting. Other Auxiliary officers are

109th Annual Session, May 2-5, 1977

DELEGATES ACT ON MAJOR ISSUES AT BILOXI

The House of Delegates at the 109th Annual Session of the Mississippi State Medical Association handled a busy agenda of 16 reports and 8 resolutions. The Official "Transactions" of the meeting will be published in the August issue of the JOURNAL MSMA.

Hearings were conducted by reference committees before which discussion and debate were heard on Monday, May 2. Also featured on Monday was the annual meeting of the Mississippi Foundation for Medical Care. The reference committees reported to the House on Thursday, May 5, where final action on all reports and resolutions took place and new officers were elected.

Among major actions by the House of Delegates were approval of reports and resolutions which:

- Went on record in support of the association taking whatever action is necessary to assure that appointments to the Mississippi State Board of Health are made in accordance with law.
- Referred for study by the Board of Trustees a resolution seeking association endorsement of Blue Cross-Blue Shield of Mississippi.
- Endorsed legislative enactment of the AMA model bill entitled "A Comprehensive Health Education Act" to provide a statewide health education program in the public schools.
- Supported expansion and strengthening of programs to combat drug dependence and stated that prescribing of amphetamines and other stimulating drugs had no rational basis in the treatment of obesity.
- Urged early development of a statewide plan to provide high risk maternal and newborn care.
- Endorsed AMA sponsored "Comprehensive Health Care Insurance Act" as a logical and workable national health care plan.
- Urged more study of economic and medical results of "surgical consultation programs" before such programs were expanded as a health insurance benefit.
- Called for AMA support to remove inequities in Medicare reimbursement between urban and rural areas of the country.
- Voted a dues increase from \$125 to \$200 per year.
- Authorized Board of Trustees to solicit funds to assist any member countersuing a nonmeritorious malpractice claim.

In other actions, the House of Delegates:

- Urged state licensure of Canadian licensed nurses by reciprocity.
- Approved election of two delegates to the House of Delegates of the association by interns and residents in the state and authorized complimentary distribution of association publications to interns and residents.
- Approved plans to organize the Mississippi Medical Fraternal and Educational Society as an association sponsored program to offer professional liability insurance to the membership.
- Established a Section on Orthopedic Surgery as one of the scientific sections of the association.
- Approved further study of a plan to require CME as a condition for membership in the association beginning in 1979.
- Reaffirmed support for an expanded role for the RN working under physician supervision.
- Scheduled the 113th Annual Session of the association in Biloxi, May 4-7, 1981.
- Presented the 1977 Robins Award for Community Service to Dr. Hugh Banks Barnes of Hattiesburg.
- Presented check to University of Mississippi School of Medicine in the amount of \$13,452.20 representing 1976 contributions to the school from Mississippi physicians and their spouses and medical alumni.

The Reference Committee on Credentials reported seating 104 delegates on May 2 and 116 delegates on May 5.

Serving as reference committee chairmen were Drs. Virginia Tolbert of Ruleville, Reports of Officers, Councils and Board of Trustees; Stanley A. Hill of Corinth, Rules and Order of Business; and W. Lamar Weems of Jackson, Council on Constitution and By-Laws.

**110th Annual Session, May 1-4, 1978, at
Jackson—Mark Your Calendar Now!**

Mesdames G. Sam Rowlett of Vicksburg, president-elect; Doyle P. Smith of Jackson, treasurer; W. A. Brown, Jr., of Mathiston, parliamentarian; J. C. Barnett, Jr., of Brookhaven, first vice president; W. P. Warfield of Moss Point, second vice president; Curtis Roberts of Brandon, third vice president; John M. Estess of Hollandale, fourth vice president.

Board of Trustees Names 1977-78 Officers

A new name appears on the roster of the association's governing body, the Board of Trustees. Elected by the House of Delegates was Dr. Ellis M. Moffitt of Jackson, representing District 5. He replaces Dr. Carl G. Evers of Jackson who retired from the Board after serving the maximum number of terms.

Dr. Arthur A. Derrick of Durant was re-elected trustee of District 4 and Dr. Joe S. Covington of Meridian was named to another term representing District 6.

Dr. Robert S. Caldwell of Tupelo, District 3, was re-elected chairman of the Board; Dr. Arthur A. Derrick was named to another year's service as vice chairman; and Dr. Gerald P. Gable of Hattiesburg, District 7, was re-elected secretary. The chairman, vice chairman and secretary make up the Executive Committee.

Continuing to serve on the Board are Drs. Whitman B. Johnson, Jr., of Clarksdale, District 1; John R. Lovelace of Batesville, District 2; Max L. Pharr of Jackson, District 5; Sidney O. Graves, Jr., Natchez, District 8; Paul H. Moore of Pascagoula, District 9; James O. Gilmore of Oxford, president; and Lyne S. Gamble of Greenville, immediate past president.

Six general officers meet with the Board: president-elect, secretary-treasurer, speaker of the House of Delegates, vice speaker and the two AMA delegates.

Scientific Assembly Begins Work for '78

The 1978 Annual Session is set for May 1-4, 1978, in Jackson. The Council on Scientific Assembly has already begun planning for the 110th.

Acting by separate sections during the recent 109th Annual Session, the 12 components of the Scientific Assembly named new chairmen and four sections elected new secretaries. In addition, one



Dr. James O. Gilmore is administered the official oath of office by Board Chairman Robert S. Caldwell. Executive Secretary Charles L. Mathews holds the historic association Bible.



Dr. James O. Gilmore of Oxford, 1977-78 president of the association, makes his inaugural remarks to the House of Delegates.



Dr. Carl G. Evers of Jackson, new president-elect of the association, addresses the House of Delegates following his election.



Dr. Hugh Banks Barnes of Hattiesburg, shown at right, is the 1977 recipient of the MSMA-Robins Award for outstanding community service. Presenting the award were Dr. Gilmore, MSMA president-elect, and Mr. Willard Duvall, A. H. Robins Company representative, pictured at left.



Dr. Lawrence W. Long of Jackson received an award from the Mississippi chapter of the International College of Surgeons in recognition of his service to his fellow surgeons as regent from 1962-66 and from 1973-77. The award was presented at an ICS breakfast on May 5.

new section, orthopedic surgery, was approved by the House of Delegates.

Under the By-Laws, a section chairman serves a term of only one year, but section secretaries are elected for three years to provide continuity. Secretaries of the sections are elected on staggered terms.

Each office carries an automatic seat and vote in the House of Delegates to assure proper representation of each scientific specialty.

Named to head the Section on Anesthesiology is Dr. Katherine Aldridge of Hattiesburg. New section secretary is Dr. David I. Carlson of Jackson.

Dr. Ronald R. Lubritz of Hattiesburg will chair the Section on Dermatology. Filling in the last two years of the secretary's term is Dr. Thomas C. Garrott of Biloxi. The previous secretary resigned after one year.

Dr. David E. Ulmer of Columbus will chair the Section on EENT and section secretary Dr. W. Joseph Burnett of Oxford enters the second year of his three-year term.

Heading the Section on Family Practice is Dr. W. K. Stewart of Pass Christian. New section secretary is Dr. Gene E. Crick of Minter City who will serve a three-year term.

The internists chose Dr. Walter T. Boone of Jackson as chairman of the Section on Medicine. Entering the second year of his term as section secretary is Dr. Don Q. Mitchell of Jackson.

Dr. Richard S. Hollis of Amory heads the Section on Obstetrics and Gynecology. Dr. Wadie Abraham of Meridian enters the third year of his term of office.

Dr. J. Elmer Nix of Jackson is chairman of the newly-formed Section on Orthopedic Surgery. Section secretary is Dr. George W. Wharton of Jackson.

Pathologists chose Dr. Roland F. Samson of Jackson as chairman of the Section on Pathology. Dr. William B. Wilson of Jackson enters the second year of his term as secretary.

Dr. Robert L. Abney of Jackson will serve as chairman of the Section on Pediatrics. Section secretary is Dr. Robert H. Thompson of Jackson.

Dr. C. Earl Fox of Tupelo will chair the Section on Preventive Medicine. Entering the third year of his term as section secretary is Dr. W. E. Riecken of Jackson.

New chairman for the Section on Surgery is Dr. Benton M. Hilbun of Tupelo. Dr. Jerry R. Adkins of Biloxi enters the second year of his three-year stint as secretary.

Chairing the Section on Psychiatry will be Dr.

J. Ed Ruff of Jackson. Dr. Glen Anderson of Brandon continues as secretary of the section.

Heading the Section on Radiology is Dr. James T. Trapp of Tupelo and secretary Dr. Bernard Blumenthal of Jackson enters the third year of his term as secretary.

Dr. J. Elmer Nix of Jackson, association secretary-treasurer, is constitutional chairman of the Council on Scientific Assembly. He said that the council will be meeting this summer to review preliminary plans for the 110th Annual Session and to begin actively working on the program.

The exhibit prospectus for technical exhibitors will be released this fall. Specialty societies are invited to submit plans for concurrent meetings and requests for assignments of rooms, including those for meal occasions, he added.

The president, Dr. James O. Gilmore of Oxford, and the president-elect, Dr. Carl G. Evers of Jackson, are *ex officio* members of the council.

Specialty Societies Hold Concurrent Meetings

More than 15 specialty societies and related groups met concurrently with the association during the 109th Annual Session at the Sheraton-Biloxi. Scientific sessions and social occasions drew members of almost every specialty.

Psychiatrists from throughout the state attended the May 1 luncheon meeting of the Mississippi Psychiatric Association. Officers are Drs. James Ed Ruff of Jackson, president; G. Howard Freeman of Meridian, president-elect; Glen Anderson of Brandon, secretary; and B. Steve Smith of Jackson, treasurer.

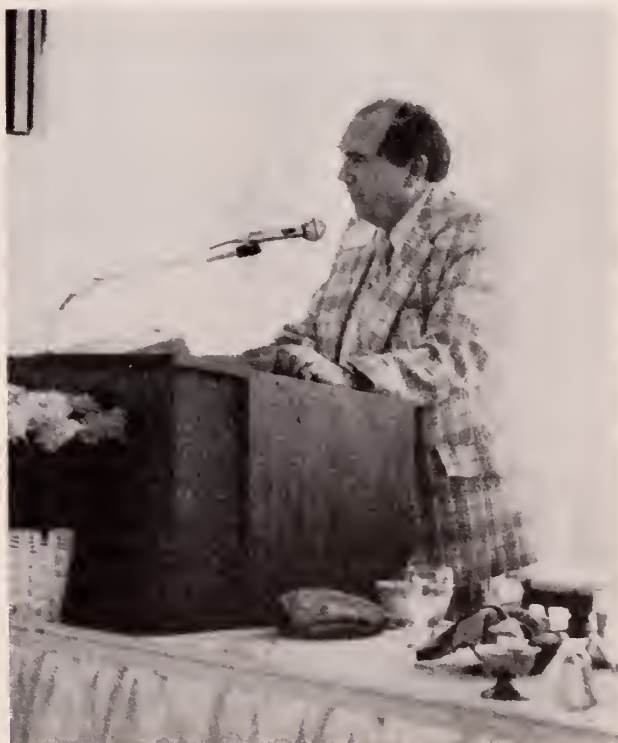
A special postgraduate seminar on genitourinary problems was presented on Sunday, May 1, by the Mississippi Urological Society. The society also held a business meeting and luncheon on Monday, May 2. Dr. William C. Gates of Columbus is president; Dr. Toxey M. Morris of Hattiesburg is president-elect; and Dr. Ronald L. Brown of Gulfport is secretary-treasurer.

The Mississippi Association of Pathologists held a business meeting and luncheon on Sunday along with their section meeting. Officers are Drs. Roland F. Samson of Jackson, president; Allen M. Read of Natchez, president-elect; William B. Wilson of Jackson, secretary; and David R. Steckler of Natchez, treasurer.

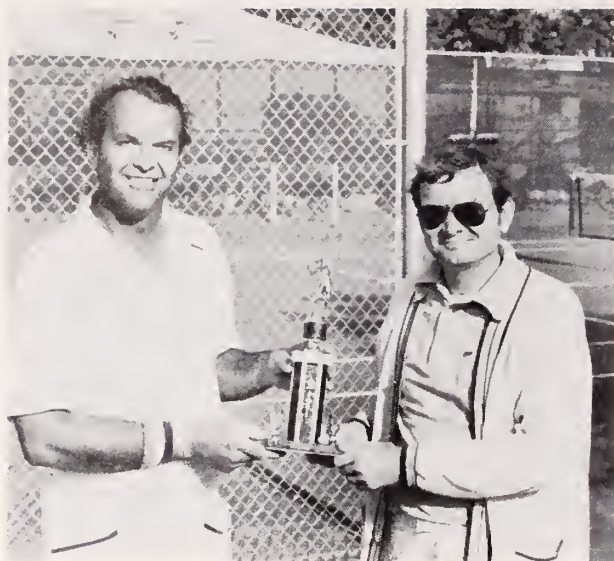
The Mississippi Society of Anesthesiologists met



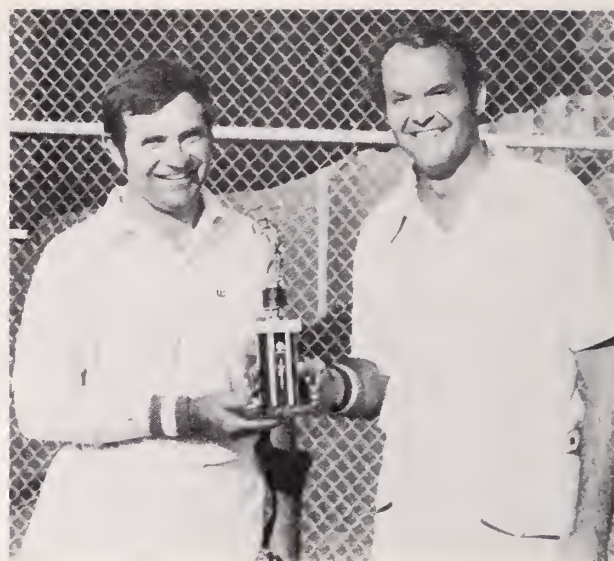
Presenting the check for AMA-ERF contributions to Dr. Norman C. Nelson (second from right), vice chancellor of the University of Mississippi, is Dr. James O. Gilmore, at left. Assisting in the presentation are Dr. Charles Farris of New Orleans, Ole Miss medical alumni president, at right, and Mrs. Pat Warfield of Moss Point, Auxiliary AMA-ERF chairman.



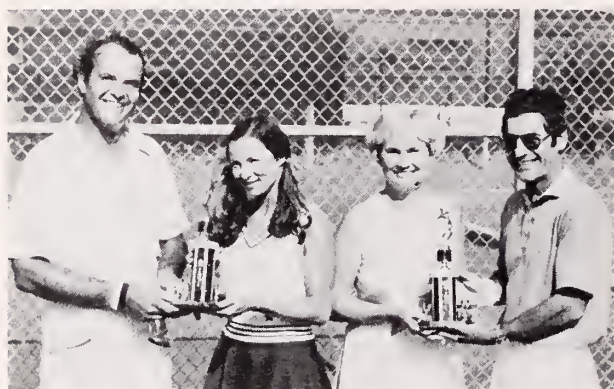
Dr. Edgar T. Beddingfield, Jr., of Stantonburg, NC, chairman of the AMA Council on Legislation, was guest speaker at the Mississippi Academy of Family Physicians luncheon on May 4.



MSMA held its first annual men's and women's doubles tennis tournament during the 109th Annual Session. Top left, first place winner in the men's division was Dr. John Lucas of Greenwood, shown at



right. Presenting the trophy is Dr. Henry B. Tyler of Jackson, tournament chairman. Top right, second place winner in the men's competition was Dr. James O. Manning of Jackson, at left.



Winners in the women's division competition were Mrs. Carol Lee of Corinth (second from left), first place, and Mrs. Dolores Alexander of Laurel, second place. Assisting Dr. Tyler in the trophy presentation was David McNamara (far right), of Healthco/Mississippi Surgical of Jackson, sponsor of the tournament.

on Sunday, May 1, for a business meeting, the MSMA Section on Anesthesiology, and a dinner. Dr. Katherine Aldridge of Hattiesburg is president; Dr. Dexter C. Nettles of Jackson is president-elect; and Dr. David I. Carlson of Jackson is secretary-treasurer.

Orthopedic surgeons convened on May 2 for a scientific meeting and luncheon. New officers are Drs. J. Elmer Nix of Jackson, president; Royce H. Franks of Tupelo, president-elect; George W. Wharton of Jackson, secretary; and Hugh P. Brown of Jackson, vice president.

The Mississippi Dermatological Society hosted a breakfast and a luncheon on Tuesday, May 3, in conjunction with their business and section meetings. President is Dr. Ronald R. Lubritz of Hattiesburg and secretary-treasurer is Dr. Tom Garrott of Biloxi.

Internists specializing in or interested in gastroenterology met for an organizational meeting on Tuesday, May 3. Newly elected officers are president, Dr. Walter T. Boone of Jackson; secretary, Dr. Joel T. Callahan of Meridian; and executive committee members, Drs. Leonard Posey of Jackson and Jim Spence of Hattiesburg.

The Mississippi chapter of the American College of Surgeons convened on May 3 for a luncheon, scientific session and business meeting. New officers are Dr. John R. Lovelace of Batesville, president; Dr. James D. Hardy of Jackson, president-elect; and Dr. W. Briggs Hopson of Vicksburg, secretary-treasurer.

A luncheon meeting highlighted the annual gathering of the Mississippi Society of Internal Medicine. Dr. James C. Hays of Jackson is president and Dr. Bruce E. Atkinson of Amory is secretary-treasurer.

The American Academy of Facial Plastic and Reconstructive Surgery, Mississippi chapter, hosted a breakfast, business and scientific meeting on May 4. Officers are Drs. Kenneth N. Reed of Jackson, president; George Arrington, Jr., of Meridian, vice president; and J. George Smith of Jackson, secretary.

The academy also sponsored video cassette showings of soft tissue surgery during the annual session.

Radiologists in the state convened for a cocktail party on May 3, following their section meeting. Officers of the Mississippi Radiological Society are Drs. Clifton L. Hester of Jackson, president; Charles A. Ray of Meridian, president-elect; John Y. Gibson of Jackson, secretary; Frank S. Hill of Columbia, first vice president; and James T. Trapp of Tupelo, second vice president.

The Mississippi Ob-Gyn Society held a luncheon meeting on Wednesday, May 4. Officers are Drs. Kenneth Pittman of Jackson, president; H. Lamar



Dr. Lyne S. Gamble of Greenville, 1976-77 MSMA president, was unable to attend the annual session due to illness. Mrs. Elizabeth Thompson, sponsor of the James Grant Thompson Memorial Past President Pin, came up from the Coast on May 16 to present the pin to Dr. Gamble at the University Medical Center. She is assisted in the presentation, which took place on University Hospital grounds, by Dr. Carl G. Evers of Jackson, MSMA president-elect.

Gillespie of Hattiesburg, president-elect; Lewis Lipscomb of Jackson, vice president; and Fred H. Ingram of Jackson, secretary-treasurer.

Family physicians met at a Mississippi Academy of Family Physicians luncheon on May 4. Dr. Edgar T. Beddingfield, Jr., of Stantonburg, NC, chairman of the AMA Council on Legislation, was guest speaker. Officers are president, Dr. Walter Rose of Indianola; president-elect, Dr. Ralph Brock of McComb; vice president, Dr. John Estess of Hollandale; and secretary-treasurer, Dr. Edgar Johnson of Hattiesburg.

The Mississippi EENT Association held a luncheon and business meeting on May 4. Officers are



Officers of the Mississippi Urological Society are, from left, Drs. Ronald L. Brown of Gulfport, secretary-treasurer; William C. Gates of Columbus, president; and Toxey Morris of Hattiesburg, president-elect.

Drs. J. Leighton Pettis of Tupelo, president, and Wilson E. Moak of Jackson, secretary-treasurer.

Flying physicians in Mississippi were guests at a Flying Physicians Association, Mississippi chapter, dinner and program on Wednesday, May 4. Dr. H. Davis Dear of Jackson is president and Dr. W. E. Riecken of Jackson is secretary-treasurer.

A Short Course in Practical Tonometry for Non-Ophthalmologists was again sponsored by the Mississippi Society for the Prevention of Blindness.



New officers of the Mississippi Society of Internal Medicine are from left, Drs. James C. Hays of Jackson, president; Walter Boone of Jackson, MSMA section chairman; and Bruce Atkinson of Amory, secretary-treasurer.



The Mississippi chapter of the American College of Surgeons held a luncheon and scientific session at the Sheraton-Biloxi. Officers are Dr. John R. Lovelace of Batesville, president, right, and Dr. James D. Hardy of Jackson, president-elect.



New officers of the Mississippi EENT Association are from left, Drs. Bob May of Jackson, representative of AAO; Leighton Pettis of Tupelo, president; and Wilson E. Moak of Jackson, secretary-treasurer.



New officers of the Mississippi Orthopedic Society are from left, Drs. Hugh P. Brown of Jackson, vice president; J. Elmer Nix of Jackson, president; R. H. Franks of Tupelo, president-elect; and George Wharton of Jackson, secretary.



New officers of the Mississippi chapter, American Academy of Facial Plastic and Reconstructive Surgery are from left, Dr. J. George Smith of Jackson, secretary; Dr. Kenneth Reed of Jackson, president; and Dr. George Arrington, Jr., of Meridian, vice president.



Mississippi Ob-Gyn Society elected the following officers at their meeting on the Coast: from left, Dr. Richard Hollis of Amory, new chairman of the MSMA Section on Ob-Gyn and immediate past president of the society; Dr. Ken Pittman of Jackson, president; and Dr. Lewis Lipscomb of Jackson, vice president.

UMC Newborn Art Exhibit Scheduled

The second annual University of Mississippi Medical Center newborn art competition exhibit is June 26 at the Medical Center in Jackson.

The contest, sponsored by the UMC Newborn Center and the March of Dimes, is designed to increase public awareness of the importance of perinatal care.

The 1977 contest entries, illustrating some aspect of maternal and infant care or the artist's perception of a mother and baby, will be displayed and contest winners announced at formal showing from 2 p.m. to 4 p.m. in the Oglevee Building auditorium.

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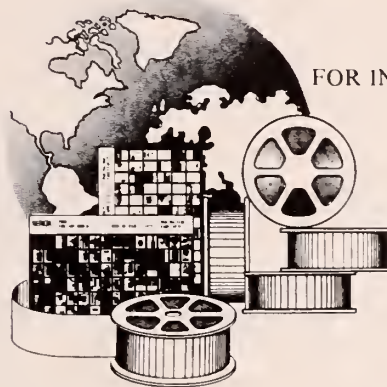
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IN CONCLUSION

Mental health experts estimate that 80 per cent of all emotional problems evidenced on the job are the results of stressful relationships and situations outside of work, according to Metropolitan Life Insurance Co. studies. But the emotional problems such as loss of work, frustration of unfulfilled expectations, etc., that occur as a result of emotional stress on the job can be just as serious. These people deserve recognition and help in the business setting and should get the same fair handling and opportunities as persons with other illnesses, studies show.

Relatively simple blood tests can rule out paternity in more than 90 per cent of the cases of men who are falsely accused of fathering a child, says a joint report of the AMA and the Section on Family Law of the American Bar Association. After five years of study, the group says that for practical purposes, seven different tests will suffice. A simple comparison of the six blood group systems will rule out paternity in two-thirds of the falsely accused cases and several more tests will bring the figure up to more than 90 per cent.

AMA dues-paying membership totaled 172,830 last year, exceeding expectations in the first year of a major dues increase. The full-dues membership figure reached 152,160; resident membership was 10,506; and medical students numbered 10,164. Total AMA membership, including dues-exempt physicians and affiliate members, was 203,584 in 1976. The average age of AMA dues-paying physician members last year was 48.9; according to AMA Center for Health Services Research and Development. The average age of all U.S. physicians was 46.3.

In spite of convincing evidence that successful immunization can safely and effectively prevent diphtheria, whooping cough, tetanus, polio, mumps, measles and rubella, more than 5 million children in the U.S. are not protected against these diseases, points out an article in the May 16 JAMA. The periodic outbreaks of these diseases occur among groups of persons who have never been immunized and among others in whom immunization failures have occurred. Physicians are urged to take a leadership role in promoting immunizations.

Miscellaneous News: Recent reports indicate that various labor groups contributed \$8.2 million to congressional candidates in 1976 -- an average of \$17,500 per congressional district...The Department of Health, Education, and Welfare will be seeking non-physician review organizations after January 1, 1978, in those Professional Standard Review Organization areas where no physician sponsored organization is available. As of this date, 83 of 203 PSRO areas do not have review programs.

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psycho-

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tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

ship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Use in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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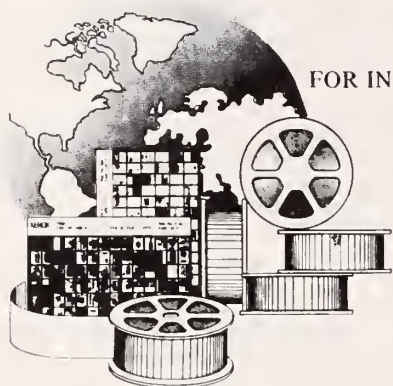


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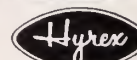
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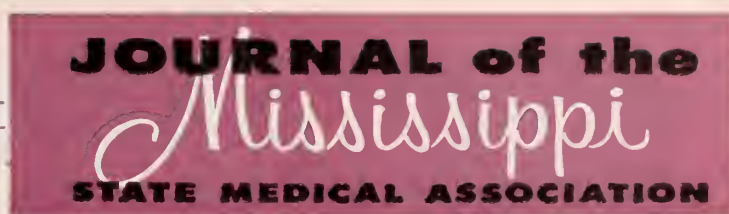
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Volume XVIII
Number 7
July 1977



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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (Publication No. 284800) is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$15.00 per annum; \$2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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For additional information contact: John R. Reedy,
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Further Clarification of Influenza Consent Statement Regarding Use of Influenza Vaccine in Conjunction With Other Immunizations

Febrile reactions may occur beginning within a day following administration of DTP (and other inactivated bacterial vaccines) and within 14 days following live measles or smallpox vaccines. Persons presenting for flu vaccination who have fevers from previously administered vaccines will be excluded from influenza vaccination until the fever has disappeared. To avoid possible coincidental reactions, influenza vaccines should not be given on the same day as DTP (or other inactivated bacterial vaccines), nor within 14 days after measles or smallpox vaccines. Other vaccines such as polio, rubella, mumps, and yellow fever are not usually associated with fever and their administration at any time does not preclude influenza vaccination.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

Native Doctor's License

The original was written in 1865 in Hawaiian.
English Translation

Certificate of a Doctor for Hawaii Nei.

It is decided to be proper that should act as a medical doctor, for under me, he having exhibited to my satisfaction his qualifications as such doctor. Therefore, I hereby give my sanction to his practicing medicine from Hawaii to Kauai, so long as he obeys my directions and observes the laws of the King of this government, and conducts himself properly and honestly.

The following is the scale of fees to which I consent, if a cure is affected:

1. Very great sickness	\$50.
2. Less than that	\$40.
3. A good deal less	\$30.
4. Small sickness	\$20.
5. Very small	\$10.
6. Attending a friend	\$ 5.
7. Incantation to find out disease	\$ 3.
8. Taking a case from another doctor	\$10.
9. Certificate of a doctor	\$ 3.
10. Refusal by the patient to pay	\$10.

Given under my hand this day of 18.....

S.W.Kapu
W.E.P.Daniels
Head of Hawaiian Doctors.

P.C. Advertiser July 15, 1865, page 2 col. 3.

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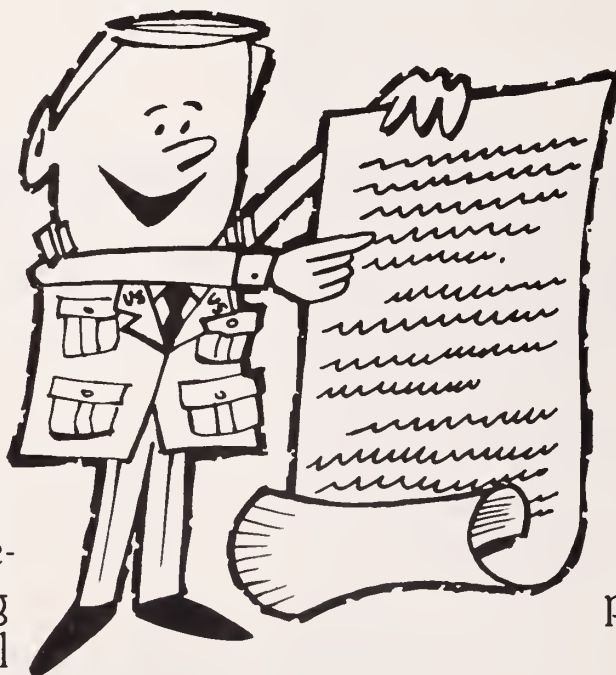
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NEWSLETTER

July 1977

Dear Doctor:

The Mississippi Medical Fraternal and Educational Society has proceeded to organize after a response from more than 600 MSMA members. The Board of the society has retained McNeary Insurance Consulting Services, Inc., of Charlotte, North Carolina, to assist in further organization of the society. McNeary recently worked with the North Carolina and Alabama medical societies in organizing "captive companies."

Mississippi Health Systems Agency, the state's single HSA, has conducted a "study" and concluded that the state needs only one agency. MSMA will protest that the choice of one HSA places all health decisions in Jackson and that the present HSA displayed prejudice and bias in its study.

Sixteen lawsuits challenging implementation of P.L. 93-641 have been filed since the planning law was enacted two years ago, according to American Hospital Association. Five suits challenge constitutionality of the law, five question area designation process, and six raise differences in opinion over designation of health system agencies.

Medical care is not the fastest rising item in the Consumer Price Index (CPI)! Medical care was at 184.7 on CPI in 1976 with 1967 = 100. By comparison, lawyers' charges were at 199.9, insurance and finance charges at 196.6 and postal charges at 222.3. Washing machine repairs were at 200.4, babysitting was 214.6 and movie tickets hit 193.8. Per capita income after taxes was at 202.0.

Billy F. Simmons has been named to succeed W. Bryan Holliday as director of the Mississippi Medicaid Commission, effective June 2. Mr. Simmons, since his retirement as a U.S. Air Force colonel, has served with the Washington Bureau of the American Hospital Association and as administrator of Jasper General Hospital, Bay Springs. Most recently he was deputy director of SHPDA.

Congress rejected a bill to extend the power of the Federal Trade Commission over nonprofit associations. The House Commerce Committee voted to continue the exemption of nonprofit groups from the formal jurisdiction of the FTC and the Senate Commerce Committee deleted the provision from its version of the bill. The AMA testified against the bill after a House subcommittee had approved the measure.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

MEETINGS

National and Regional

American Medical Association, House of Delegates Interim Mtg., Chicago, Dec. 4-7, 1977; Winter Scientific Mtg., Miami Beach, Dec. 10-13, 1977. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

Cancer Concepts 1977, Oct. 16-18, 1977, Sheraton Inn, Gatlinburg, TN. For information contact: Dr. Harvey Goodman, Department of Continuing Medical Education, University of Tennessee Center for the Health Sciences, 1924 Alcoa Highway, Knoxville, TN 37920.

Third Annual Symposium on Arthritis and Musculoskeletal Diseases, Aug. 25-27, 1977, Grand Hotel, Point Clear, AL. Sponsored by Mississippi and South Alabama chapters of the Arthritis Foundation.

State and Local

Mississippi Academy of Family Physicians, Annual Meeting, July 6-9 1977, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 110th Annual Session, May 1-4, 1978, Jackson. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Henry McCrory, Secy., P.O. Box 340, Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. G. L. Arrington, Jr., Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1167, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Charles A. Ozborn, Secy., 207 Meadow Lane, Eupora 39744. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. George Walker, Secy., 102 W. Lampkin St., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Clyde Gunn, Jr., Secy., P.O. Drawer G, Moss Point 39563. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Thomas Blake, Secy., 424 S. 13th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.



Natural balance doesn't always come naturally

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BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

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The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg/kg/day in rabbits and 10 mg/kg/day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.


Usage in Children. Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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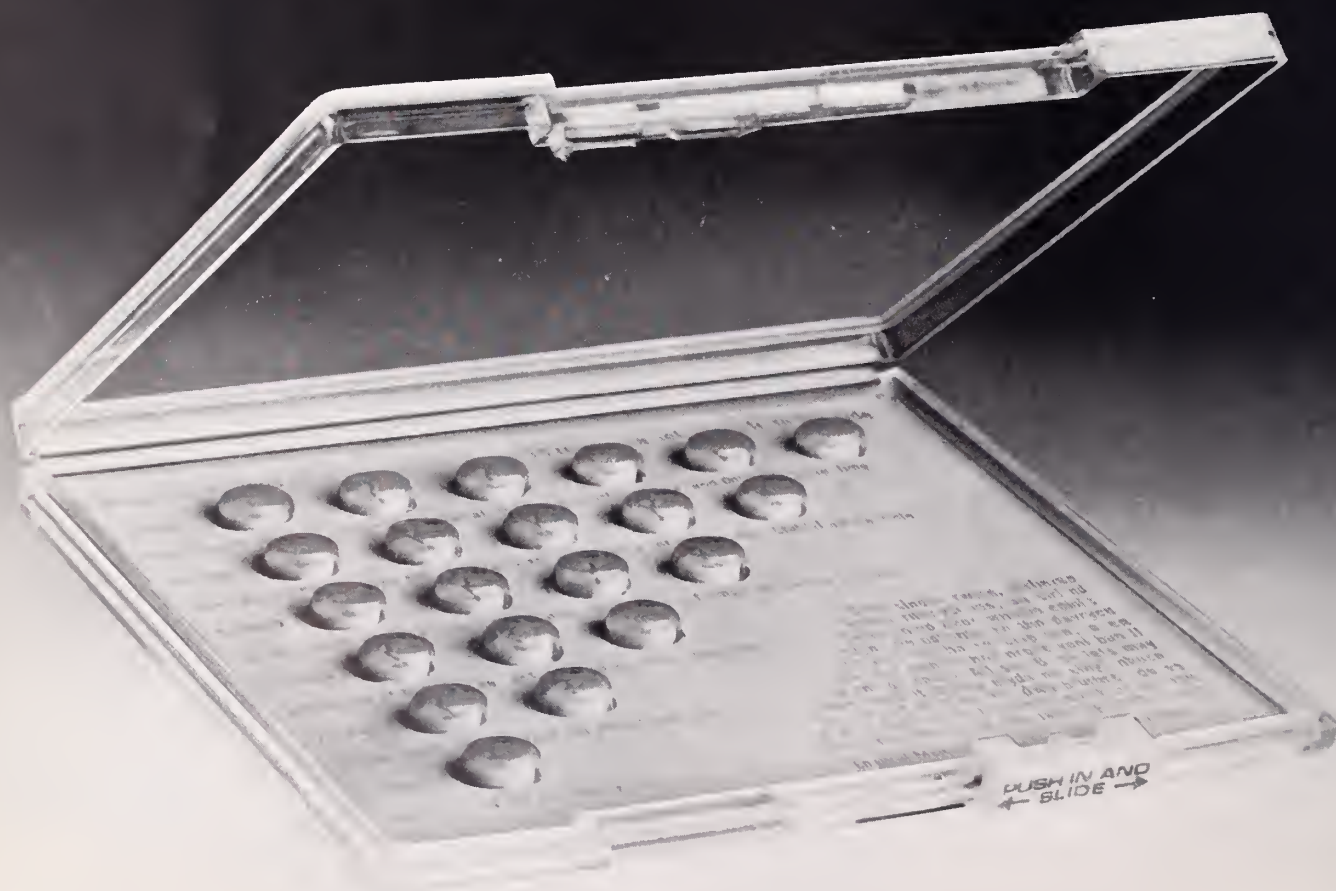
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for vertigo*

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The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.



Hospitals Are Focal Points for Suits

Two national closed claims surveys, one conducted by the Insurance Services Office (ISO) and the other by the National Association of Insurance Commissioners (NAIC), have studied the causes of malpractice claims and suggest that it is important for hospital programs to monitor and assess quality of care.

The ISO survey found that three-quarters of the nearly 10,000 claims studied, considered to be a representative sample, were against physicians. Of these, 81 per cent arose from treatment of patients in hospitals. Approximately 40 per cent of all claims reported resulted from occurrences in the operating room.

According to the NAIC survey, 58 per cent of the incidents occurring in hospitals were surgery related. The remainder were associated with routine obstetrical and non-surgical procedures.

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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DATELINE

Relative Value Scales Restricted St. Paul, MN - The Minnesota State Medical Association and 34 of its component societies signed a Federal Trade Commission consent order barring the use of relative value scales. MSMA officials said they do not admit to any violation of the law. MSMA said its relative value index "has been used as a means of coding and defining medical procedures for third party payors in both the public and private sectors." MSMA denied FTC contention that relative value index contributes to higher costs.

Junior College Is Accredited by AMA Booneville, MS - Northeast Mississippi Junior College is the first educational institution in Mississippi to receive accreditation of its program in medical assisting from the Committee on Allied Health Education and Accreditation of the AMA, in collaboration with the Curriculum Review Board of the American Association of Medical Assistants. The accredited programs provide a basic knowledge of administrative and clinical procedures and qualified physicians serve as advisors.

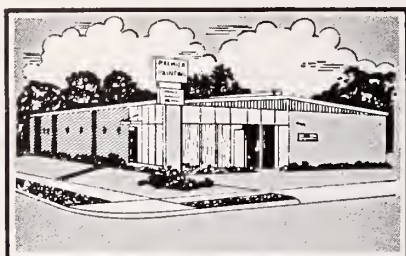
Pediatricians Opt for Recertification Evanston, IL - A voluntary program for continuing education and assessment leading to recertification in pediatrics has been announced by the American Academy of Pediatrics and American Board of Pediatrics to begin in 1979. Program will be closely tied to a comprehensive program of continuing education in pediatrics available to all physicians. AAP will have responsibility for developing educational programs and the board will be responsible for actual recertification process.

Children Need to Wear Seat Belts Chicago, IL - Many children are needlessly killed or seriously injured in auto accidents because their parents have neglected to install and use proper seat belts or other restraining devices, reported American Journal of Diseases of Children. More than 5,000 automobiles carrying children were surveyed in Maryland, Massachusetts and Virginia. Some 93 per cent of passengers under 10 years of age were not restrained. Those under 2 were usually sitting on someone's lap with no protection.

Abusers Given Choice of Therapy Goals Haverstraw, NY - People who drink to excess should be encouraged to try to get at the root of the problems that are "driving them to overdrink," and make constructive changes in their lives, says A. Winters, founder of Drinkwatchers, Inc. The two-year old educational association offers members a choice of therapeutic goals and endorses therapies such as behavior modification, rational-emotive therapy and anhedonia therapy which teaches that the opposite of abusing is treating with respect.

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Rocky Mountain Spotted Is Updated

Rocky Mountain spotted fever (RMSF), the only rickettsial disease causing significant mortality in the United States, is most common in the southeastern area of the country. Most cases occur during the spring and summer and are predominantly in children.

RMSF is a tick-borne disease caused by *Rickettsia rickettsii*. In the Mississippi area, the major tick vector is the dog tick (*Dermacentor variabilis*). The infection is maintained in nature through a cycle involving ticks and the animals they feed on. Man becomes an accidental victim of RMSF when he intrudes into the cycle and is bitten by an infected tick. An infected tick must have attached and been feeding for at least four to six hours, however, before rickettsias from the tick become reactivated and transmission can occur. Rickettsias from infected tick feces or juices can also gain access to the body through skin abrasions. Hence, crushing infected ticks can be hazardous.

A rising serum titer of complement-fixing antibody to *R. rickettsii* is diagnostic. The rise occurs in the second week of illness, or later if vigorous antibiotic therapy is given early. The Weil-Felix test for serum agglutinins to proteus OX-19 and OX-2 organisms is often not positive until late or not at all. Isolation of the rickettsial organism is hazardous and therefore not done routinely.

The overall mortality rate of untreated RMSF is 20 per cent; however, treatment with tetracyclines or chloramphenicol, when given early, is almost uniformly curative. Since serologic responses to the clinical infection of RMSF do not occur within the first week of illness and death usually occurs 7 to 14 days after onset of symptoms, physicians should not wait for a laboratory confirmation of the diagnosis to begin treatment.

RMSF vaccine is recommended for laboratory personnel working with *R. rickettsii* and possibly for persons whose occupations result in exposure to ticks in endemic areas. It is not recommended for use in the general population. RMSF vaccine usually does not prevent the disease but may reduce the severity of it.

Prevention of RMSF depends mainly on personal protection against ticks. Protective clothing and frequent examination of the body, especially the scalp, for ticks are recommended.

Ticks found on a person or pet should be removed immediately. Use tweezers or a folded piece of paper or cardboard and apply gentle traction to remove the tick intact.

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in hypertension

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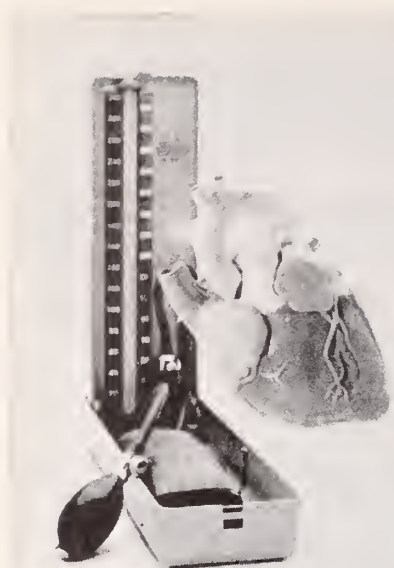
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usually with no direct effect on
cardiac function—cardiac output
is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyl dopa therapy has been associated with liver disorders. It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyl dopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

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Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

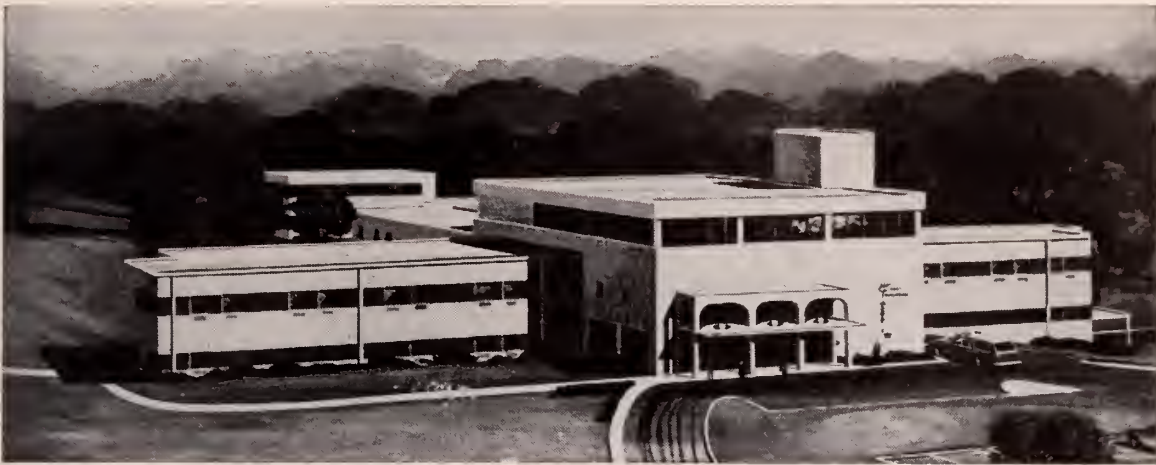
Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07 (707)

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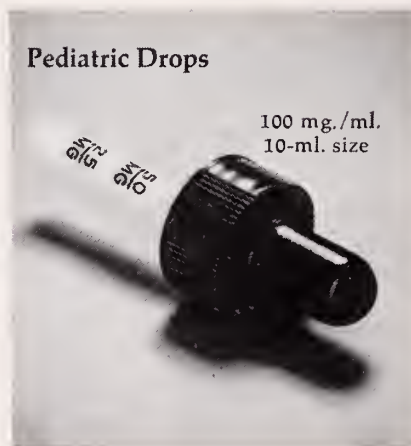
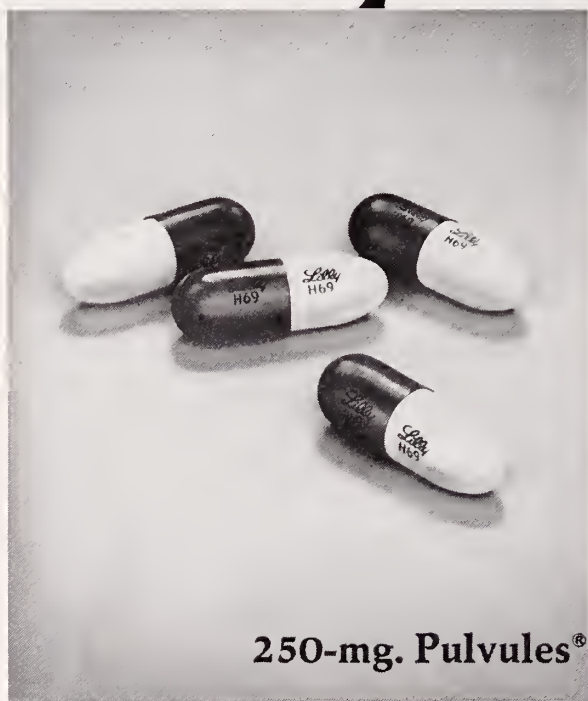
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ORIGINAL PAPERS

Recent Experience With Familial Occurrence of Atrial Septal Defect

JOHN H. SELBY, JR., M.D., FRED A. CRAWFORD, JR., M.D.,
DAVID G. WATSON, M.D., and PATRICK H. LEHAN, M.D.
Jackson, Mississippi

MOST INSTANCES of congenital heart disease, especially isolated atrial septal defect (ASD), are felt to occur in sporadic fashion and to exhibit a well defined Mendelian pattern of inheritance only in those syndromes resulting from recognized chromosomal abnormalities. The occurrence of atrial septal defect in a familial pattern has attracted some recent attention since the diagnosis and repair of congenital heart disease has become more sophisticated, reliable, and routine. Recent experience at the University Medical Center with two instances of familial atrial septal defect within a two month period prompts this brief review of considerations of atrial septal defect within a single family. Such review is worthwhile not only for the purpose of sharpening our awareness as to the possible presence of more than one affected member in a family, but also for consideration of aspects related to genetic counseling for parents.

Case Reports

D. J. and J. J. are two white male brothers, ages five and seven, who were both noted to have asymptomatic murmurs at the ages of two and five, respectively. The older child was found to have a murmur on routine examination for kindergarten and the younger child was noted to have a murmur when examined because of respiratory infection. The only pertinent related history was that the mother had an episode of appendicitis at six months gestation with the older child. There was also a family history of diabetes mellitus; the paternal grandmother was a diabetic and the patient's father was

diagnosed as a chemical diabetic. Each of the children had a grade 2-3/6 systolic ejection murmur loudest at the second and third intercostal space at

This paper presents the case reports of two instances of familial atrial septal defect seen at the University Medical Center in Jackson. The authors then give a brief review of considerations of atrial septal defect within a single family with the aim of creating more awareness among physicians and also for consideration of genetic counseling for parents.

the left sternal border. Both had fixed splitting of the second heart sound and were noted on chest x-ray to have increased pulmonary blood flow and slight cardiomegaly. Both boys exhibited incomplete right bundle branch block on electrocardiogram. Both children underwent cardiac catheterization, and were noted to have a left to right shunt at the atrial level. The ratio of pulmonary flow to systemic flow in both children was 1.9:1. Both were found at operation in September 1976, to have secundum atrial septal defects which were closed with simple running sutures on cardiopulmonary bypass. Post-operative courses were uneventful in both cases.

B. W. and A. W. are father and son, ages 35 and 15, who were seen by their family physician for a routine football physical for the son. When the son was found to have a systolic ejection murmur at the left sternal border and wide fixed splitting of his second heart sound, it was recommended that he have further evaluation by a cardiologist. The father

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ATRIAL SEPTAL DEFECT / Selby et al

mentioned that he had had a similar murmur for some time. He was found to have the same cardiac findings on physical examination. On further questioning, it was noteworthy that the father admitted some increased dyspnea on exertion, but was otherwise asymptomatic. Electrocardiograms in both of these patients were normal. Chest x-rays revealed mild cardiomegaly with increased hilar pulmonary shadows and pulmonary vascular congestion. At cardiac catheterization, secundum ASD was confirmed. The father was found to have a left to right shunt with a pulmonary to systemic blood flow ratio of 5:1. The son had a pulmonary to systemic blood flow ratio of 3.4:1. In August 1976, both underwent repair of atrial septal defects on cardiopulmonary bypass and had uneventful recovery.

Discussion

Isolated case reports of familial occurrence of atrial septal defects began to appear with the advent of more sophisticated means for diagnosis of such congenital heart defects.^{3, 5, 19, 21} Various patterns of inheritance were postulated, according to the nature of the specific patients encountered.^{2, 3, 15, 22} An entire spectrum from Mendelian dominant patterns of inheritance to complete coincidental occurrence of ASD has been speculated. More recently, as larger numbers of familial ASD's have been assimilated, at least two separate patterns of inheritance have been isolated. The most frequent of these is the multifactorial mode of inheritance, in which both genetic and environmental influences play a role.¹² The aggregation of ASD in siblings or in several generations of a single family may be the result of a polygenic mechanism.¹⁸ A number of congenital abnormalities has been observed to occur in a recurring pattern and combined with heart defects.^{4, 6} However, with respect to isolated atrial septal defect, one group has been characterized by the presence of secundum ASD with an atrioventricular conduction defect most frequently manifest by a prolonged PR interval.^{1, 2, 11} These patients are noted to inherit their abnormality in a Mendelian dominant pattern. That is, 50 per cent of the children of the affected parent will manifest the abnormality. In the Holt-Oram syndrome, which includes atrial septal defect in combination with abnormalities of the forearm and hand (usually the radial aspect), patients are likewise noted to inherit the abnormality in a Mendelian dominant pattern, and may or may not manifest conduction defects.¹⁶

In Mendelian inheritance the risk to the unborn after one affected child is one in two for those in-

volving a dominant gene, and one in four for those with the recessive. However, in multifactorial inheritance, the risk increases with the number of affected individuals in the family. Certain requisites must occur in order to fulfill the criteria for multifactorial inheritance.¹⁴ First, the disease must be relatively common. As a category, congenital heart disease is the most common congenital malformation. ASD is found in 10 to 15 per cent of patients with congenital heart disease. Next, familial aggregates must occur; such occurrence with ASD is well documented. Thirdly, the recurrence rate in sibs must be between 1 and 5 per cent. A number of observers has noted a sibling occurrence of isolated ASD of 2 to 4 per cent.^{13, 14, 15, 18} (With two affected siblings, risk of recurrence may be greater than 5-8 per cent.)⁶ Finally, there must be evidence of response to environmental influence. Comparison of the expected frequency of ASD among siblings according to multifactorial inheritance with the observed occurrences shows close correlation.^{14, 15}

A definite nonspecific increase in the frequency of congenital heart disease in families that are already affected has been observed. Numerous environmental factors have been observed to play a role in the inheritance of congenital heart disease in general.¹⁰ Exposure to drugs or viral infection is well recognized as a determinant in the incidence of congenital heart disease. Radiation exposure and hypoxemia are further examples of the known influence of environment in inducing congenital heart disease. The role of environment in congenital heart disease had been explored in animal models, but is difficult to pursue in humans. It is postulated that Mendelian inheritance may sometimes be simulated in circumstances in which phenotypic expression is controlled by a large number of genes. Manifestation of an observed defect may be related in some way to a biologic threshold. The environmental factors may then be instrumental in phenotypic expression by alteration of the threshold.¹⁵ The hereditary transmission of congenital heart disease has been inconstant, though many large studies note an increased incidence of congenital malformations in close relatives of those already affected. Though studies of identical twins have shown a lack of concordance for specific congenital cardiac defects, it is noted that "familial clustering" may result from an interaction of genetic and environmental factors.¹¹ Specifically, studies of familial incidence of congenital heart disease have shown a recurrence rate in siblings of 1.5 to 5 per cent compared to the incidence of 0.6 to 0.8 per cent in the general population.^{6, 9, 13} Again, the exceptions are noted to be

those syndromes previously mentioned which usually have been attributed to a single mutated gene or to a Mendelian dominant characteristic.

Notation of the incidence of familial congenital heart disease is valuable from several standpoints. Most simply, it directs attention toward more careful scrutiny of other family members in patients known or suspected to have congenital heart disease. The early diagnosis and treatment of congenital defects is a worthwhile pursuit even in instances of relatively benign abnormality such as ASD. Mortality of atrial septal defect is only 0.7 per cent per year in the first decade, and there is no significant mortality until the third decade.¹⁷ However, patients with atrial septal defect are known to have an increased inclination to recurrent respiratory infections, arrhythmias, and episodes of congestive heart failure. Many patients with longstanding atrial septal defects are asthenic and underdeveloped. If the childhood course is uncomplicated, symptoms may appear in early adulthood. The most ominous occurrence is an increase in pulmonary vascular resistance, which changes an easily curable lesion into a relatively incurable one.²⁰ Apparently, there is an individual susceptibility to this particular adverse development. Accurate predictions as to age of onset cannot be reliably made. In one review of patients over the age of 40 with atrial septal defects, the majority was found to have significant symptoms and 45 per cent were disabled to the extent that they were classified as Class III or Class IV (NYHA).⁷ Thirty-three adults (ages 40-65 years) with ASD were recently reported in an operative series.⁸ Eighty-eight per cent were functional Class III or IV before surgery.

If a patient is found to have findings compatible with an ASD by physical examination, other siblings and family members should be carefully examined. Cardiac catheterization should then be performed when such a defect is suspected. It is generally recommended that patients with a pulmonary blood flow that exceeds systemic blood flow by 50 per cent should have operative repair of the defect. Morbidity and mortality with surgical repair are low; complications infrequently alter the course, and clinical and hemodynamic improvement are predictable.

Summary

The familial occurrence of atrial septal defect is well documented. Previous observers have suggested that atrial septal defect may be inherited as either Mendelian dominant or recessive, with gross chromosomal aberrations, following teratogenic exposure, or by parameters of multifactorial inheritance. The

last of these seems to be the most credible by virtue of observed characteristics of occurrence and recurrence. Atrial septal defect fulfills the criteria of multifactorial inheritance by occurring with appropriate frequency, by showing a familial tendency, and by demonstrating a recurrence risk in siblings of 1 to 5 per cent. The familial occurrence with such defects is more than just of coincidental interest in that it should stimulate us to scrutinize more carefully the family members of affected individuals, and should provide us some guidelines in genetic counseling. Exceptions to the occurrences according to a pattern of multifactorial inheritance are those instances of atrial septal defect which occur as part of a separate syndrome.

Atrial septal defect most frequently follows a benign course throughout childhood and adolescence of the affected individual. The low mortality rate is generally related to such complications as respiratory infections, congestive heart failure, arrhythmia, or rheumatic heart disease. In adulthood, patients are frequently affected with progressive fatigability, dyspnea on exertion, palpitations, and arrhythmias. Because of these progressive symptoms and because operative repair now can be carried out with extremely low risk, closure of ASD should be undertaken at the time of diagnosis.

★★★

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Guidelines for Detection, Diagnosis, Treatment, and Follow-Up of Radiation Related Thyroid Cancers

W. MEL FLOWERS, JR., M.D., and JANE A. SANDERS, M.D.

Jackson, Mississippi

BEGINNING IN THE early 1920's, thousands of infants and children received radiation therapy for benign diseases of the head and neck; enlargement of the thymus, hypertrophy of the tonsils and adenoids, cervical adenitis, mastoiditis, sinusitis, tinea capitis, eczema, acne, hemangiomas and keloids. The thyroid gland frequently received direct or scattered radiation during these treatments. Short-term results were usually excellent, but an increasing number of articles have appeared in the literature reporting the discovery of both benign and malignant tumors of the thyroid gland. The peak incidence of neoplasia is between 5 and 30 years after exposure, but the patients are apparently at risk for life. Only a small percentage of these individuals develop lesions and the tumors found are frequently benign. Most malignant neoplasms are well differentiated papillary and/or follicular carcinomas which grow slowly, metastasize reactively late, and are curable by surgery while still localized.

This topic has been dealt with extensively in the medical literature and in the news media. The recent presentation on a CBS-TV "60 Minutes" television magazine has had remarkable impact on public awareness. The result was an unusually large number of inquiries to practicing physicians, hospital radiology departments, nuclear medicine facilities, and regional centers of the American Cancer Society. A flood of calls and letters, including all inquiries sent to CBS were directed to the National Cancer Institute.

This problem has been addressed by several national and regional organizations, including the American Cancer Society, National Cancer Institute, American College of Radiology, Mississippi State Radiological Society, and others. Most of these organizations have published statements or guidelines, and these are available to the practitioner who must

confront the individual patient and manage his problem. Although there are expected minor differences of opinion and philosophies of approach, the major recommendations are remarkably similar. The concerned patient is usually referred to the physician of his choice, and the following points are stressed: the necessity for medical evaluation, the low incidence of cancer, and the high probability of cure. The need for the practitioner to become informed as to the most appropriate management for these patients is universally recognized.

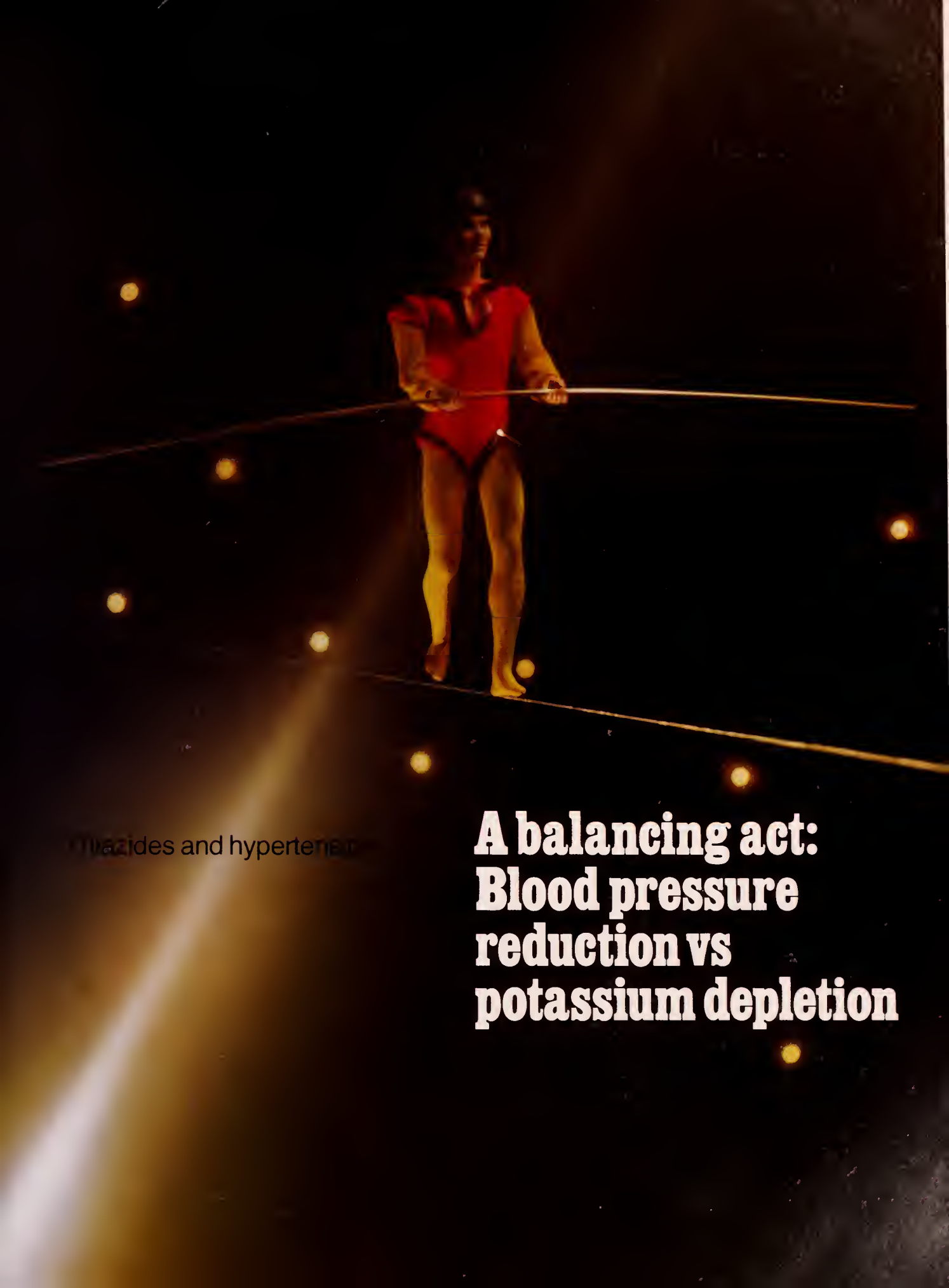
Thyroid cancer without a history of previous radiation exposure is a relatively rare disease. Approximately one case in 27,000 individuals is expected in the general population. However, there seems to be little doubt that patients who receive therapeutic doses of ionizing radiation to the head, neck or upper thorax during infancy or childhood are at increased risk of developing thyroid cancer. One hundred asymptomatic individuals were recalled for examination at the University of Chicago because of a history of radiation to the head and neck. Palpable abnormalities in the thyroid were found in 26 per cent, and there were 7 malignant tumors in 15 patients explored surgically. Michael Reese Hospital recalled 1,056 patients, analyzed 182 of 195 explored surgically, and 33 per cent of these had carcinomas.

Identification of Patients at Risk

It is impossible to recall every patient who received radiation therapy to the head and neck during infancy and childhood. Many important treatment records have been destroyed or are unavailable for other reasons. Hospital departments of radiology that have such records have been and should be encouraged to institute recall programs. However, the educational approach could prove to be a very effective means of reaching those at risk. Physicians are seeing a significant number of patients who are self referred.

The most important part of the clinical evaluation is the history and the physical examination. The his-

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Division of Nuclear
Medicine, The University of Mississippi Medical Center,
Jackson, MS.



Thiazides and hypertension

A balancing act: Blood pressure reduction vs potassium depletion

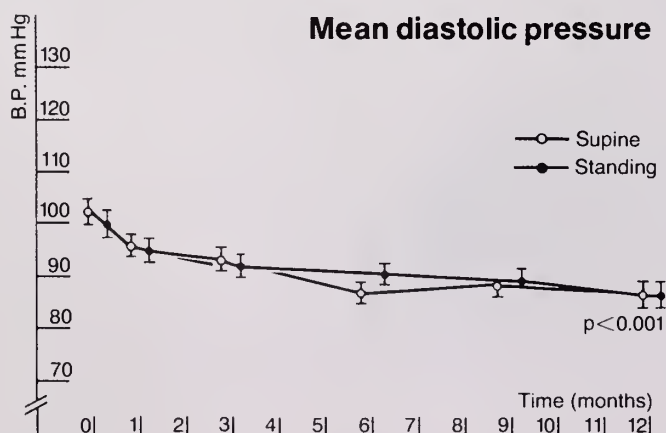
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"The patients were receiving a single daily dose of 10 mg bendrofluazide [bendroflumethiazide]...there were no apparent side effects from the medication."

*Wilkinson PR et al: The Lancet 1:759-762, 1975.



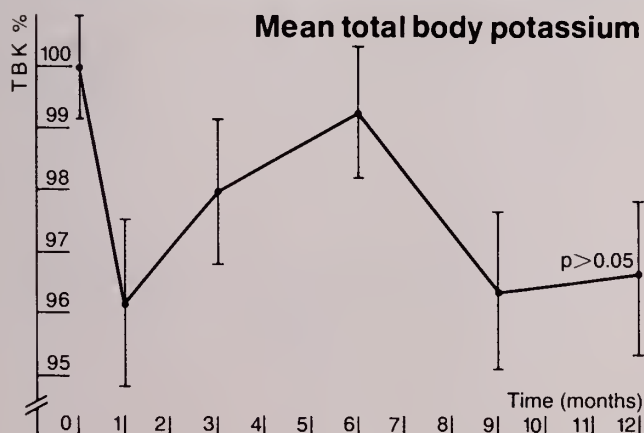
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2.5, 5 and 10 mg

Potassium stabilized at 96% mean TBK



"The amount of potassium loss during the period of study did not seem to be clinically significant."

"A serum potassium of less than 3.5mmol per litre is often taken as the value below which potassium supplements should be given...At an arbitrary lower value for serum potassium of 3.0mmol per litre, few patients, our data suggest, would need potassium supplements. Our findings with TBK support this view..."

See next page for full prescribing information.

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NATURETIN[®]-2.5

NATURETIN[®]-5

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Bendroflumethiazide Tablets N.F.

DESCRIPTION

Naturetin (Bendroflumethiazide Tablets N.F.) is a benzothiadiazine derivative containing a benzyl and a trifluoromethyl group. It is a potent oral diuretic and antihypertensive agent available as compressed tablets providing 2.5, 5.0, or 10 mg. bendroflumethiazide.

ACTIONS

The mechanism of action results in an interference with the renal tubular mechanism of electrolyte reabsorption. At maximal therapeutic dosage all thiazides are approximately equal in their diuretic potency. The mechanism whereby thiazides function in the control of hypertension is unknown.

INDICATIONS

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated as adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis and corticosteroid and estrogen therapy.

Bendroflumethiazide has also been found useful in edema due to various forms of renal dysfunction such as: nephrotic syndrome, acute glomerulonephritis, and chronic renal failure.

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated in the management of hypertension either as the sole therapeutic agent or to enhance the effectiveness of other antihypertensive drugs in the more severe forms of hypertension.

Usage in Pregnancy. The routine use of diuretics in an otherwise healthy woman is inappropriate and exposes mother and fetus to unnecessary hazard. Diuretics do not prevent development of toxemia of pregnancy, and there is no satisfactory evidence that they are useful in the treatment of developed toxemia.

Edema during pregnancy may arise from pathological causes or from the physiologic and mechanical consequences of pregnancy. Thiazides are indicated in pregnancy when edema is due to pathologic causes, just as they are in the absence of pregnancy (see WARNINGS). Dependent edema in pregnancy, resulting from restriction of venous return by the expanded uterus, is properly treated through elevation of the lower extremities and use of support hose; use of diuretics to lower intravascular volume in this case is illogical and unnecessary. There is hypervolemia during normal pregnancy which is harmful to neither the fetus nor the mother (in the absence of cardiovascular disease), but which is associated with edema, including generalized edema, in the majority of pregnant women. If this edema produces discomfort, increased recumbency will often provide relief. In rare instances, this edema may cause extreme discomfort which is not relieved by rest. In these cases, a short course of diuretics may provide relief and may be appropriate.

CONTRAINDICATIONS

Bendroflumethiazide is contraindicated in anuria.

It is also contraindicated in patients who have previously demonstrated hypersensitivity to it or other sulfonamide-derived drugs.

WARNINGS

Bendroflumethiazide should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may be additive or may potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers. Thiazides appear in breast milk. If use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS

Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: dryness of the mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes mellitus may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS

Gastrointestinal System: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), and pancreatitis.

Central Nervous System: dizziness, vertigo, paresthesia, headache, and xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, and aplastic anemia.

Dermatologic-Hypersensitivity: purpura, photosensitivity, rash, urticaria, and necrotizing angitis (vasculitis, cutaneous vasculitis).

Cardiovascular: orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics. **Other:** hyperglycemia, glycosuria, occasional metabolic acidosis in diabetic patients, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, and restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSAGE AND ADMINISTRATION

Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

Diuretic: The usual dose is 5 mg. once daily, preferably given in the morning. To initiate therapy, doses up to 20 mg. may be given once daily or divided into two doses. A single daily dose of 2.5 to 5 mg. should suffice for maintenance.

Alternatively, intermittent therapy may be advantageous in many patients. By administering the preparation every other day or on a three to five day per week schedule, electrolyte imbalance is less likely to occur; however, the possibility still exists.

In general, the lowest dosage that achieves the therapeutic response should be employed.

Antihypertensive: The suggested initial dosage is 5 to 20 mg. daily. Maintenance dosage may range from 2.5 to 15 mg. per day, depending on the individual response of the patient. When the diuretic is used with other antihypertensive agents, lower maintenance doses for each drug are usually sufficient.

STORAGE

Store at room temperature; avoid excessive heat.

HOW SUPPLIED

2.5 mg. tablets in bottles of 100, 5 mg. tablets (scored) in bottles of 100 and 1000, and 10 mg. tablets (scored) in bottles of 100.

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tory of exposure should be confirmed and documented. The original records should be obtained if possible. Considerable confusion and unnecessary anxiety can be avoided if both the physician and patient clearly differentiate between radiation treatment and x-ray diagnostic studies: it is almost always the therapeutic procedures that cause concern. The incidence of thyroid cancer increases with increasing doses of thyroidal radiation from 6.5 rads to 1,500 rads, but higher doses tend to destroy the gland and are associated with hypothyroidism rather than neoplasia.

Since most patients with radiation related thyroid tumors are asymptomatic, a question about prior radiation exposure should be a routine part of any patient's history. A patient may have discovered a mass in the neck; this should increase the suspicion for carcinoma. A history of persistent hoarseness and difficulty in swallowing could indicate relatively advanced disease.

Physical examination requires both palpation and inspection. Palpation should include the thyroid gland, cervical lymph nodes, and salivary glands. Inspection of the neck, especially on swallowing, may reveal a mass or asymmetry that might be overlooked by palpation alone. Indirect laryngoscopic examination is recommended if there is hoarseness, if the patient is being considered for surgery, or if cancer is suspected. T3 and T4 studies may be unrewarding because most patients with thyroid neoplasms have normal thyroid function studies.

Thyroid Scanning

Some physicians believe that thyroid scans contribute little useful information in this situation; others obtain a scan on all patients at risk. The radioactive iodine uptake is seldom needed for evaluation of these patients; and technetium 99m pertechnetate (Tc-99m) is the scanning agent of choice. It results in a radiation dose to the thyroid on the order of 1/100 of that delivered by iodine-131.

Most malignant lesions present as areas of decreased concentration of radioactive isotope and are therefore "cold" on scan. Up to 50 per cent of these "cold" lesions are malignant in this patient group. A malignant "hot" nodule is relatively rare.

Suggested Classification and Diagnostic Sequence

All patients at increased risk should be examined periodically at least every two years during their lifetime. Patients may be divided into three categories on the basis of the physical examination.

1. Those with no visible or palpable abnormality.
2. Those with a discrete nodule or nodules on palpation.
3. Those with diffuse enlargement of the thyroid gland without palpable nodule.

Category I: Thyroid Gland Normal to Palpation

If palpation of the thyroid gland by an experienced observer reveals no abnormality, a thyroid scan is not absolutely mandatory. Many physicians prefer to obtain a scan whether the gland is clinically normal or not, and some patients request that the scan be done. If a scan is done and is considered normal, clinical re-examination and re-evaluation is recommended every two years. Repeat scans are usually reserved for those patients who demonstrate a change in the gland on subsequent physical examination.

If the scan reveals a cold or non-functioning area in the gland and there is no palpable abnormality, the situation becomes most difficult. The patient should be re-examined, preferably by two or more physicians experienced in the evaluation of the thyroid. If re-examination reveals a small nodule missed on the initial evaluation, the patient should be considered for surgical exploration. If no nodule is felt, there are three alternatives:

1. The patient may be followed by careful palpation at yearly intervals.
2. To prevent the development of thyroid nodules, the patient may be placed on suppressive doses of thyroid hormone and continued on maintenance levels indefinitely. Such patients should be reexamined annually for the presence of nodules, the adequacy of thyroid therapy, and to ascertain that the thyroid hormone is not producing thyrotoxicosis.
3. Surgical exploration can be considered. Many experts prefer to keep the patient under annual observation until a nodule becomes palpable. This issue is not completely settled, because up to 27 per cent of cold lesions without a palpable nodule have been found malignant.

Category II: Discrete Palpable Nodule(s)

There is a consensus that one or more firm discrete nodules should be surgically removed regardless of the scan findings. The scan is occasionally useful for determining the functional status of a nodule. Cold nodules should be considered for prompt surgical exploration. Even though hot nodules are not usually malignant, many experts recommend surgical removal. Small (less than 1.5 cm.), soft and poorly demarcated lesions with a normal scan may be given

a trial of thyroid hormone for 6 months. If there is no regression surgical exploration is recommended.

Category III: Diffuse Enlargement Without Nodule(s)

Diffuse thyroid enlargement in a patient with normal thyroid function is usually secondary to benign hypertrophy or to lymphocytic thyroiditis. A scan should be done. If there are no areas of abnormal isotope concentration, the patient may be placed on suppressive therapy to shrink the hypertrophied tissue; this may conceal a very deep nodule. Re-examination in 6 months is recommended. If a nodule becomes palpable, surgical exploration is indicated. If no nodule is palpable, the patient may be re-examined annually and continued on thyroid therapy indefinitely.

If the patient's scan shows a definite cold area but no palpable nodule, he should be placed on thyroid hormone and re-examined in 6 months. Surgical exploration is usually reserved until a nodule becomes palpable.

Definitive Therapy

Surgical resection is indicated in any patient with radiation to the head or neck with one or more palpable firm discrete nodules in the thyroid gland. Thyroidectomy is associated with significant risk and should be undertaken only by experienced thyroid surgeons. Most post-surgical patients will require replacement thyroid hormone therapy. They should be reevaluated at least annually in order to detect recurrence and to determine the adequacy of replacement hormone. If unresectable cancer remains in the neck or distant metastases are detected, the patient should be referred for consideration of treatment with radioactive iodine-131, chemotherapy, or radiation therapy.

Conclusions

Individuals who received therapeutic doses of X or gamma radiation to the head, neck, and upper thorax for various non-malignant conditions during infancy or childhood must be considered at increased risk of developing thyroid cancer. These patients should be clinically evaluated at a minimum of two year intervals during their lifetime. Certain selected patients will require more frequent re-evaluation. Findings on history and physical examination are the most important factors in determining the course of action. While there is no universal agreement as to the role of the thyroid scan in this situation, there appears to be little doubt that the scan results can often be decisive in patient management. ★★★

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For a selection of free publications and visual aids on lung diseases and related subjects, including cigarette smoking and air pollution, contact the Mississippi Lung Association, 353 N. Mart Plaza, Jackson, MS 39206.

Radiologic Seminar CLXXII: Gray Scale Ultrasound in Pancreatic Pseudocyst

JOHN Y. GIBSON, M.D.

Jackson, Mississippi

OF ALL THE morphological information that ultrasound provides that which it most accurately conveys is whether or not a given mass is cystic or solid. The dots that make up an ultrasound image represent sound wave reflections occurring at interfaces between tissue of differing acoustic properties. Since fluid is of a uniform density and does not contain tissue interfaces to reflect ultrasound, no echoes are demonstrated within a fluid filled mass such as a cyst. Also the marked difference between the acoustic properties of fluid and that of solid tissue results in a well defined margin surrounding a cyst. Since fluid does not attenuate (decrease the intensity of) the sound beam to the same degree as the surrounding soft tissue, there is the appearance of enhancement of the beam. This comes from the relatively greater intensity of echoes arising from the tissue on the side of the cyst opposite the transducer (enhanced back wall). These basic principles provide the three characteristic features of a cyst:

1. Echo-free mass
2. Well defined borders
3. Enhanced through sound transmission

A pseudocyst has the same ultrasound features as a true cyst.

Pancreatic pseudocyst is a collection of fluid in the region of the pancreas or within its parenchyma resulting from an insult to the pancreas that has caused disruption of the pancreatic ductal system. The most common causes are pancreatitis (90 per cent) and trauma (10 percent). Pancreatic pseudocysts more often result from alcohol related acute pancreatitis than from pancreatitis associated with biliary tract disease. Pseudocysts are not always single. In the series reported by Duncan and Blumgart, 22 per cent were multiple.

As demonstrated by B mode, gray scale ultrasound, pseudocysts appear as oval or elliptical shaped echo-free masses with well defined margins and enhanced through sound transmission. Although they originate in the retroperitoneum of the upper abdomen, pancreatic pseudocysts may dissect into

unusual locations and have appeared in the pelvis, the groin, the mediastinum and have even extended into the neck. Pseudocysts arising from the body or head of the pancreas may extend far anteriorly and come in direct contact with the anterior abdominal wall. Although most of the space occupied by a pseudocyst appears echo-free, it is not unusual for there to be a layer of coarse echoes posteriorly representing debris pooling at the dependent portion of the fluid filled cavity. This collection of echoes can be shown to shift to the dependent corner of the pseudocyst upon changes in the position of the patient such as from supine to right lateral decubitus.

Inflammatory masses differ from pseudocysts in their ultrasound appearance. An inflammatory mass will have poorly defined margins and will not show enhanced through sound transmission because of attenuation. Such a mass may not be entirely echo free but may contain scattered low intensity echoes.

A pseudocyst may be simulated by a fluid filled stomach. When this is suspected the insertion of a nasogastric tube and the use of suction can eliminate the confusion. Cysts of other organs such as kidney, adrenal and spleen may have an appearance that would suggest a pseudocyst but careful scanning in several planes should show the relationship of such cysts to their parent organ. Pseudocysts spontaneously regress in 8 per cent of the cases and complications occur in 33 per cent. The most common complications are rupture, hemorrhage and ascites.

At the present time ultrasound provides the most efficient means of confirming the diagnosis of pseudocyst and is also the most practical way to follow the progress of this condition when conservative management is indicated. Added benefits are the noninvasive nature of the procedure and the complete lack of hazard to the patient from radiation or other forms of potential tissue injury. ★★★

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Sponsored by the Mississippi Radiological Society.

From the Division of Diagnostic Ultrasound, Department of Radiology, University of Mississippi Medical Center, Jackson, MS.

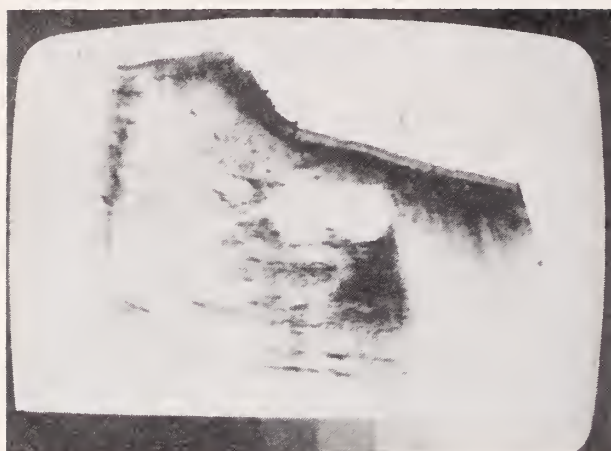


Figure 1. Longitudinal scan showing diaphragm to the left. Pancreatic pseudocyst appears as an echo-free mass inferior to liver and anterior to right kidney.

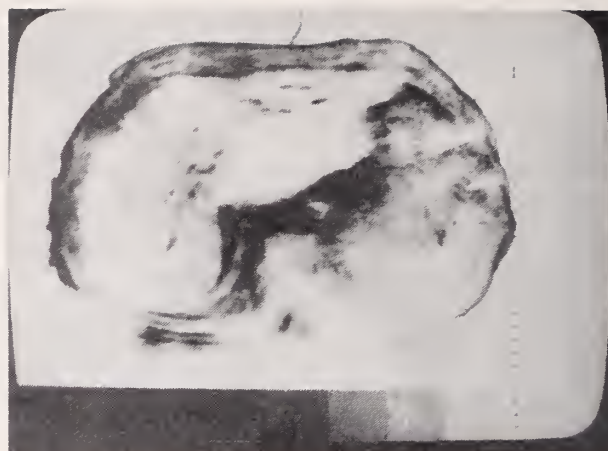


Figure 2. Transverse scan. The pseudocyst is demonstrated as an elliptical echo-free area between the spine and the left lobe of the liver.



Figure 3. Longitudinal scan. The pseudocyst appears as an oval shaped echo-free mass between the liver anteriorly and the aorta posteriorly. A smaller pseudocyst is located inferior to the larger one.

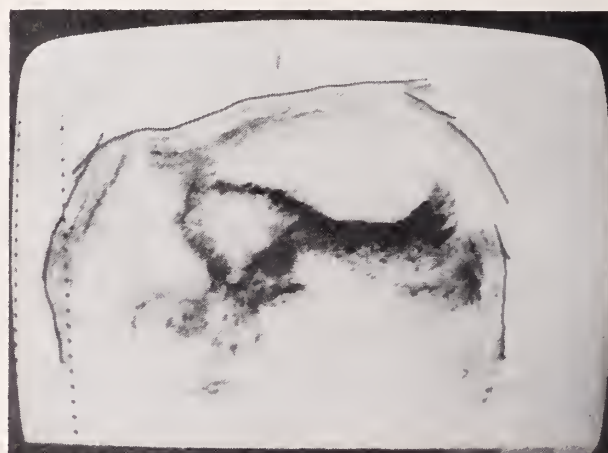


Figure 4. Transverse scan. Large pseudocyst at left side of upper abdomen has a layer of debris at its base.

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Address of the President

LYNE S. GAMBLE, M.D.
Greenville, Mississippi

THIS HAS BEEN an eventful year. On the national scene a new administration which is dedicated to a national health insurance plan has taken office. Here at home, we find ourselves being sued for following a law that has been adhered to by every administration in this state since the law was passed in 1926.

One could almost be led to pessimism by these events and others of a like nature. But I would urge them to remember that all that "glitters is not gold." Or to state it another way, there is not enough money to finance the "glittering" national health insurance programs that some in Washington have proposed. And here at home the "glittering" statements by the governor with respect to his State Board of Health activities will not hide the fact that he did not obey the law.

The observation has been made that good laws can be made bad and bad laws can be made worse by those charged with their administration.

Last year our annual session was held during the debacle called the organization of Mississippi's Health Systems Agency. You will recall that this was implementation of Public Law 93-641, the Health Planning Law. In accordance with a directive of the House of Delegates, an official protest was lodged with the Department of HEW. I feel that many of the conditions imposed upon MHSA when it was later funded were a direct result of our protest.

For the future, I would remind all concerned of the original name of the current health planning law. It was the "Partnership for Health Act." Then as now, medicine has to be an equal partner in health planning if it is to be successful. As with the automobile from Detroit, Mr. Nader can certainly express "consumer desires," but the car has to be built by experts. Parenthetically, somewhere along the way the bill has to be added up, too.

Finally, with respect to our state's health planning activities, I would urge that the state be divided into more than one health systems area. That way we would truly have local control in health planning activities instead of direct control from Jackson as we have now under sub-area councils which are merely advisory.

President, Mississippi State Medical Association. Read before the House of Delegates, 109th Annual Session, Biloxi, May 2, 1977.

Last fall the NBC Today Show conducted two scientific polls within a span of a few weeks. In the first poll the question was asked, "Are you in favor of a national health insurance program?" Some 60 per cent of the respondents stated they were. In the second poll the question was asked "Are you in favor of a national health insurance program financed by increased taxes?" Some 60 per cent of the respondents said they were not.

The conclusion to be drawn from this, if any, is that the public is in favor of a national health insurance program that doesn't cost any money. There is, of course, no such program available. This poll vividly illustrates to me that we must do a better job of informing the public about health care and its cost.

There are several proposals for national health insurance before Congress.

There is a category of proposals represented by the Kennedy-Corman Health Security Act which would totally federalize this country's health care. Financing would largely come from increased Social Security taxes.

There is another category of proposals best represented by the AMA's Health Insurance System Act which would provide full health care for all persons through the private health insurance industry. Financing would come through employer and employee contributions. The poor and medically indigent would be covered by insurance premium subsidies.

To me, the sharing of health risks by private insurance carriers, as proposed in the AMA bill, is as American as apple pie. I believe, too, that it is time for the federal government to realistically fund programs of health care for the poor.

There is a lot of what I would call statistical nonsense or just plain nonsense about health care being perpetrated on the public today.

For example, we have recently seen statements by elected officials in our state citing high maternal and infant mortality rates as indications of poor health care and need for more physicians, hospitals and other health resources. If such statistics were indicative of health needs, then one would expect the District of Columbia which has more physicians and hospitals per population than almost any area of the country to have low rates. Instead, the maternal and infant mortality rates in the district are

PRESIDENT'S ADDRESS / Gamble

comparable to our state's.

The greatest improvements in the health of our people and the largest abatement of health care costs can come from improved individual understanding and responsibility for their health.

Heart disease, cancer, stroke and accidents are the largest and most expensive killers of people in our state and nation today. The billions of dollars the public spends both individually and through taxes for treatment of these four killers could be greatly reduced if people would stop eating, drinking, smoking and speeding too much.

Medicine can treat these killers. We have only limited, if any, success in preventing them. I think we are quickly approaching the time in this country when we must answer the question of whether we are going to continue to use tax supported health care resources and monies to treat health problems that result from abuse of one's self. Perhaps an answer lies in the approach our legislature took this past year by enacting a tax on alcoholic beverages to treat alcoholics.

Individual health understanding and responsibility should begin with our youth. I commend to your attention a proposal before you at this annual session from our Council on Medical Service to seek legislative enactment of a bill to require sequential health education in our public schools.

Turning to other matters, I wish to emphatically bring to your attention the fact that the quest of some groups to diagnose and treat disease without benefit of a medical degree continues unabated.

The "modus operandi" is to obtain by legislative act what was not obtained by education and training. It is important that we continue to discuss these matters with our local legislators.

We should also seek court action, if necessary, to enforce the medical practice act of our state.

Before you at this meeting is a detailed plan to establish a continuing medical education requirement in our association. The CME requirement is similar to that enacted by many national and state medical societies.

In contrast to these professionally sponsored, vol-

untarily assumed programs, some nine states require CME as a condition for annual renewal of the license to practice medicine. I hope that you will consider this matter carefully. I personally do not believe that a CME requirement should affront or work a hardship on any of us. To me, it's merely documenting what we are already doing.

Medicare and Medicaid continue as sources of inequities and abuse with respect to physicians' services. Fees for physicians' services in Mississippi under Medicare are still much lower than for comparable services in other areas of the country and Medicaid fee schedules are even lower.

The position of the American Medical Association is that physicians' services should be reimbursed on the basis of usual, customary and reasonable fees. I certainly don't argue with that principle, but it offers no immediate relief to our situation. I am happy to see our Council on Medical Service propose to you that the association prepare a pamphlet on Medicare and Medicaid reimbursement inequities for distribution in our offices. We need to better inform the public about this matter.

Last, but certainly most importantly, we have a recommendation before you for a dues increase. The matter to me is quite simply whether we wish to go forward or stand still as a professional association. I believe, too, that it is imperative that we resist any effort to politically manipulate the State Board of Health and this will cost money.

We are now among the lowest states in dues. With the increase we will still be comparable to similar size state associations and under what many so-called health groups in the state put up each year to influence the legislature against us.

This has indeed been an eventful year and I appreciate very much the opportunity afforded me to participate in it as your president.

The support of the membership, the cordiality of component society meetings, the pleasure of working with dedicated members of our Board and councils, and a skilled, efficient and cheerful staff more than compensated for some of the arduous and troublesome problems that were encountered. Thank all of you on behalf of Polly and myself. ★★★

P.O. Box 1277 (38701)

*"And that physician who makes only small mistakes
would win my hearty praise."*

Hippocrates

On Ancient Medicine

—from Massachusetts Physician

In Appreciation

The many fine technical exhibitors who participated in the exhibit during the recent Mississippi State Medical Association 109th Annual Session are deserving of our recognition and a hearty "Thank You!" Not only did the presence of these exhibits enhance the educational quality of our meeting, but the support provided by our exhibitors is essential to the continuance of our traditionally outstanding scientific program.

The firms listed below participated in our 1977 annual meeting exhibit and we voice a collective expression of our sincere appreciation. May we also suggest that you retain this listing and express your personal appreciation when their representatives call upon you.

General Medical Jackson, Jackson, MS
 Meyer Laboratories, Inc., Ft. Lauderdale, FL
 Lanier Business Products, Jackson, MS
 Riverside Hospital, Jackson, MS
 Dista Products Company, Indianapolis, IN
 Ayerst Laboratories, New York, NY
 The Travelers Insurance Co.-Medicare, Jackson, MS
 Sandoz Pharmaceuticals, E. Hanover, NJ
 Deposit Guaranty National Bank, Jackson, MS
 Mallinckrodt, Inc., Hazelwood, MO
 Comatic Laboratories, Inc., Houston, TX
 Systemedics/AMS, Laurel, MS
 Warren-Teed Pharmaceuticals, Inc., Horsham, PA
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 Ames Co., Div. of Miles Labs, Elkhart, IN
 South MS Computer Services, Inc., Gulfport, MS
 A. H. Robins Co., Richmond, VA
 Syntex Laboratories, Inc., Palo Alto, CA
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Heyer-Schulte	Mead Johnson Laboratories
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Mississippi Association of Public Health Physicians	

Special Sponsorship—President's Reception

Blue Cross-Blue Shield of Mississippi



The President Speaking

On Private Medical Care

JAMES O. GILMORE, M.D.
Oxford, Mississippi

THE PRESIDENT has promised us a National Health Service enacted in a piece-meal approach. Speaking before a group of 140,000 HEW employees, he promised them the first part of the program by the end of the year.

He did not speak of an insurance plan, but a health service. It is clear that he means a completely federally controlled socialized medical system. This means government doctors on civil service pay, government owned and subsidized hospitals, government controlled drugs and prescribing of same for our patients and total control of our patients' medical care.

It will take the all-out effort of doctors and patients if we are to succeed in stopping the destruction of our present medical system, which is the best in the world.

There are two questions that doctors must be able to answer if socialized medicine is to be stopped:

- 1) How do we take care of poor and older patients? In 1964 Medicare and Medicaid were passed by Congress with a definite commitment that these programs would take care of the poor and elderly. If our poor and elderly citizens are still in need of medical care, then we can assume the government is not capable of providing medical care for them. There may not be an answer to this question, but the public should demand that the government make these programs a success before expanding them.
- 2) How are people with catastrophic illness to be cared for? We should tell and educate the public about purchasing catastrophic insurance. With 180 million people having some type of health insurance, this can be accomplished with just a little effort.

Economists tell us we cannot afford socialized medicine. It has been projected that total socialized medicine will cost some 200 billion dollars a year. This nation cannot afford this type of expense, so we will have a rationed patient medical care system. Patients will not like this system and neither will physicians. Let us all pledge our time and effort to stop socialized medicine.

On another important subject, did you know that premiums for professional liability insurance in Mississippi are now projected to increase some 400 per cent during the period 1977-1981? They are and that's a fact!

Answers to this and other important questions concerning the Mississippi Medical Fraternal and Educational Society are available from your association headquarters, members of your Board of Trustees and general officers of MSMA. Please don't pass up or postpone the opportunity to become a member of this organization. ★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XVIII, NUMBER 7

JULY 1977

Organized Medicine

While it is true that most bureaus or organizations tend to expand—sometimes beyond reasonable necessity—and that at best some part of their financial support is devoted to justifying their existence, these things are not true of our Mississippi State Medical Association—nor of its Auxiliary.

While dues increase and voiced dissatisfaction is heard, those who participate in organized medicine easily see the unstinting and unselfish efforts of our directors and many committee members, who donate their time for the best interests of all our members. They pay the same dues you and I pay; yet they work without compensation and with little acclaim.

Our state organization is at “eye level,” and it becomes apparent that, if you read the “blue sheet,” the JOURNAL MSMA, and the many other releases, the membership is not overtaxed for the benefits received.

The MSMA Auxiliary could easily justify an employed secretary/treasurer half time; yet to date this work has been accomplished by members without compensation. The Auxiliary, originally intended I suppose as a fraternal group to support their physician husbands, doing charity work in the community, supporting small scholarships, etc., is beginning to make itself properly appreciated. Its potential as a powerful lobbying group is daily becoming more apparent, and its financial support of AMA-ERF now reaches into the five-figure bracket annually. The Auxiliary needs and deserves your support.

The AMA is a massive organization, with innumerable benefits to its members in the way of literature and continuing education, and in lobbying for what is considered our best interests. It is a democratic organization. All organized medicine needs our support.

W. MONCURE DABNEY, M.D., Editor
Crystal Springs, MS

Medico-Legal Brief

“Captain of the Ship” Doctrine Rejected by Texas Supreme Court

On Jan. 12, 1977, the Texas Supreme Court, in two separate medical malpractice suits, rejected the “captain of the ship” theory of liability.

In the first suit, the Texas Supreme Court ruled that an appellate court should not have held an operating surgeon liable for the negligence of hospital nurses for failing to make a proper sponge count during surgery.

The malpractice suit was filed by a patient who suffered injuries resulting from the failure to remove a sponge from her abdominal cavity after an operation. She named the operating surgeon and the hospital as defendants in the suit. A jury found that the surgeon was not negligent in failing to look for the sponge before closing. It found that the nurses failed to make a correct sponge count and that this negligence was the proximate cause of the patient's injury. The trial court rendered judgment against the hospital only, but an appellate court reversed on the ground that the surgeon was liable under the captain of the ship doctrine.

Reversing the appellate court's decision, the Supreme Court rejected the captain of the ship theory of liability. Under that theory the operating surgeon was liable for the negligence of all persons participating in the procedure, even though they were not employees or borrowed employees of the surgeon. The Supreme Court said that the theory was a false special rule of agency. The liability of surgeons should be determined by the same rules of agency law that apply to others.

The three nurses were neither employees of the surgeon nor were they his borrowed servants. The circulating and scrub nurses performed their functions according to the hospital's policy and proce-

MEDICO-LEGAL / Continued

dure manual and were not directed by the surgeon in performing the sponge count.

The trial court's judgment against the hospital was proper and should be affirmed, the Supreme Court said.—*Sparger v. Worley Hospital, Inc.*, Docket No. B-5721 (Tex.Sup.Ct., Jan. 12, 1977).

In the second suit, the Texas Supreme Court ruled that the captain of the ship doctrine did not apply to render a surgeon liable for the negligence of the nurses who assisted him during surgery.

Claiming that a sponge was left in his abdomen during surgery, a patient filed suit against the operating surgeon and the hospital. The patient took a non-suit against the hospital after it settled the claim against it for \$10,000. The surgeon brought the hospital back into the case by bringing a third-party claim against it for contribution. A jury found that the patient suffered damages in the amount of \$42,300. The court rendered judgment against the surgeon for \$21,150 on the theory that he was entitled to contribution from the hospital for half the amount of the damages. Since the hospital had already settled with the patient for \$10,000, he could not recover the balance of the recovery.

The patient appealed, arguing that the surgeon was solely liable for the negligence of the nurses in the operating room on the basis of the captain of the ship doctrine. He contended that he was entitled to the full amount of damages. The jury found that the surgeon left a sponge in the patient's retroperitoneal cavity but that he was not negligent in doing so. He was negligent in failing to x-ray the patient, which would have revealed the presence of the sponge. The nurses were found negligent in failing to make a correct sponge count.

The appellate court reversed the case and remanded the case for a new trial. The court disapproved the captain of the ship doctrine and said that the surgeon's liability should be determined by the borrowed servant rule.

Affirming the decision, the Supreme Court rejected the captain of the ship theory, which made the surgeon liable even though negligence may be that of a person who is not his employee or his borrowed servant. The surgeon's liability must be measured by the standards common to other employers. The jury found that the nurses were employees of the hospital, not borrowed servants of the surgeon. The jury had not considered the question of the nurses' negligence and proximate cause, and that question should be reviewed on remand, the

Supreme Court said.—*Ramon v. Mani*, Docket No. B-5769 (Tex.Sup.Ct., Jan. 12, 1977).

Editor's Note: A previous decision in the *Sparger* case was reported in *The Citation*, Vol. 32, No. 11, p. 124. A previous decision in the *Ramon* case was reported in *The Citation*, Vol. 33, No. 9, p. 97.

THE LITERATURE

Book Reviews

Growth, Maturation and Aging—An Etiology. By Tadayoshi Imaizumi, M.D. 118 pages. Tokyo: Kugayama Press, 1976.

This is a 118-page monograph which restates and attempts to clarify and classify ideas regarding growth, maturation and aging. The general subject matter with which the book deals is more philosophical than data that can be applied to an immediate better understanding of these complex subjects. The ideas discussed are not organized in such a way that I was brought to a new understanding of any of these subjects. I believe that the receptive readership of this monograph would be quite limited.

T. E. STEVENS, M.D.
Jackson, MS

Current Medical Diagnosis and Treatment. By Marcus A. Krupp, M.D., and Milton J. Chatton, M.D. 1066 pages. Los Altos: Lange Medical Publications, 1977. \$16.00.

Covering such a varied range of subjects and such a variety of disease entities of a worldwide distribution with clarity, precision, succinctness and, yet, not slighting any of the topics, is a large order. This 16th Annual Revision fulfills this objective admirably.

The book is divided into 33 chapters plus a very useful appendix and excellent index, covering many subjects, but concentrating on those which the busy general practitioner or the internal medicine specialist will likely see in his office. One outstanding feature of the book is that each subject is followed by the pertinent bibliography on a page-by-page basis. There are chapters on general symptoms and knowledge basic to every organ system, as well as those chapters devoted to the diseases and maladies of each system and in each chapter the essence of the knowledge necessary to diagnose and treat the conditions covered is very concisely presented.

There was a minimum of illustrations in the book, presumably due to the limitations of space. A very good section on drugs interfering with chemical tests would have been nicely complimented by a section on drug interactions. The use of synonyms in certain places would have been helpful to the reader familiar with older terminology.

This book would be an excellent addition to the library of the busy general practitioner in day-to-day practice and with the bibliography incorporated into the text, as noted above, is not only a useful reference but also points the way toward further study in depth of each subject. It is well worth its \$16.00 price.

WILLIAM L. CARTER, JR., M.D.
Meridian, MS

LETTERS

SIRS: A World Health Organization (WHO) Expert Committee recently reaffirmed a statement released in 1970 concerning the effects of smoking cigarettes on health. It states that "smoking-related diseases are such important causes of disability and premature death in developed countries that the control of cigarette smoking could do more to improve health and prolong life in these countries than any single action in the whole field of preventive medicine." The specific effects of smoking in lung cancer as outlined by the WHO Committee, are summarized here-with:

The increase in lung cancer mortality in those countries where cigarette smoking has been widespread continued without interruption. In some countries, such as the United Kingdom and the United States, there is a leveling-off of mortality rates among men under 60 years of age, for whom cigarette consumption reached a plateau 20 years ago. In women, whose cigarette consumption has been rising rapidly in the past 30 years, lung cancer mortality continued to rise at an increasing rate. Mortality rates from lung cancer are 10 times greater in smokers than in persons who have never smoked. Cessation of smoking reduces this differential gradually so that after 10 years the mortality rate for these ex-smokers approaches that for persons who never smoked. This indicates that widespread cessation of smoking would rapidly reduce lung cancer mortality.

In the United States smoking was considered to

be responsible for 68,000 of the estimated 84,000 lung cancer deaths in 1976. Lung cancer risks increase directly with the number of cigarettes smoked every day, total lifetime number of cigarettes smoked, and depth of inhalation. Lung cancer is also inversely related to age: the younger one starts smoking, the greater the risk of disease. The use of filter tips and low-tar content cigarettes has been shown to reduce slightly the risk of developing lung cancer; the risk is higher than that in nonsmokers, however.

Smokers with occupational exposures to asbestos and uranium have an increased risk of dying from lung cancer. Asbestos workers who smoke have 90 times the risk of developing lung cancer than non-smoking, nonexposed persons. The risk of lung cancer among uranium miners who smoke is 4 times greater than for smokers who are not miners. The uranium and asbestos industries have only slightly increased lung cancer rates in nonsmokers.

Bronchitis and Emphysema: Extensive studies in a number of nations confirm that pulmonary function of cigarette smokers is impaired in every known respect when compared to nonsmokers. The prevalence of cough and expectoration in both men and women is closely related to the number of cigarettes smoked; these symptoms usually abate once a person stops smoking. Recurrent episodes of respiratory infection, associated with this excess secretion of mucus, are more frequent in cigarette smokers than in nonsmokers. Retrospective and prospective studies demonstrate that cigarette smoking is responsible for approximately 70% of chronic bronchitis and emphysema cases. Death rates from respiratory diseases are higher in smokers than in nonsmokers, accounting for about 25,000 deaths each year. When young patients stop smoking, pulmonary function may return to normal. Even in persons with moderately severe obstructive disease, stopping smoking may result in striking improvement in dyspnea and cough, with some improvement in ventilatory function.

Coronary Heart Disease: The most important specific effect that smoking cigarettes has on health is the development of premature coronary heart disease (CHD). Cigarette smokers have a significantly higher risk of CHD morbidity and mortality. Long-term epidemiologic studies of healthy populations confirm that a cigarette smoker is more likely to have a myocardial infarction and to die from CHD than a non-smoker. Cigarette smoking is one of the major risk factors for CHD and acts in combination with elevated blood pressure, elevated serum cholesterol, and other risk factors. Heart disease caused 648,540 deaths in the United States in 1975. Cigarette smok-

LETTERS / Continued

ing is considered responsible for approximately 25 per cent of these deaths. Stopping smoking and controlling other risk factors can reduce morbidity and mortality of CHD.

Other Cancer: In addition to developing lung cancer, cigarette smokers have a significantly higher rate of cancer of the larynx, pharynx, oral cavity, esophagus, pancreas, and urinary bladder. Pipe and cigar smokers have elevated risk of developing cancer of the oral cavity, pharynx, larynx, and esophagus when compared to non-smokers.

Pregnancy: Mothers who smoke cigarettes during the second and third trimesters of pregnancy have been found to have babies with a lower average birth weight than babies of non-smoking mothers. This effect is probably the result of higher levels of carboxyhemoglobin in the fetal circulation. An increase in perinatal mortality has been observed in babies born to smoking mothers, particularly when other factors which affect perinatal mortality exist. Stopping smoking is recommended during pregnancy.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

PERSONALS

MAXWELL C. COOKE has associated with the Ob-Gyn Clinic Group, P.A., at 500-G East Woodrow Wilson in Jackson for the practice of obstetrics and gynecology. Other members of the clinic are C. T. HULL, L. D. LIPSCOMB, BLANCHE LOCKARD, and W. B. WIENER.

DAVID DUNN and RICHARD LEUNG recently began their practices of general pulmonary medicine and cardiology in Olive Branch. Their offices are located at 9170 Pigeon Roost Road.

CLAUDE EARL FOX, III, of Tupelo, recently certified by the American Board of Preventive Medicine, has been elected a Fellow of the American College of Preventive Medicine.

SERGIO G. GONZALEZ of Laurel has been elected to fellowship in the American College of Physicians.

MICHAEL E. JABALEY of Jackson and UMC was visiting professor at George Washington University Medical Center in Washington, D. C., and at Johns Hopkins University in Baltimore during June.

HENRY L. KNAIVE and Mrs. Knaive of Laurel were honored at St. Elmo's Baptist Church with a reception in honor of their dedication and devotion to community life.

LYNN B. McMAHAN of Hattiesburg announces the removal of his office for the practice of ophthalmology to 212 Highway 49 By-Pass (South 26th Avenue).

GEORGE W. MEYER of Ocean Springs has been elected to fellowship in the American College of Physicians.

FRANCIS S. MORRISON of Jackson and UMC presented an invited lecture on future directions in blood banking to the Tri-State Blood Bank Association meeting in Des Moines, Iowa. He also spoke to the Indiana Academy of Family Physicians in Indianapolis.

PATRICIA C. MOYNIHAN of Jackson and UMC is new president-elect of the Mississippi Heart Association. CECIL T. WILLIAMS, JR., of Laurel is the new MHA secretary. District directors are L. J. OWENS of Woodville, JOE M. ROSS of Vicksburg, WALTER H. ROSE of Indianola, W. T. TAYLOR of Clarksdale, RICHARD H. RUSSELL of New Albany, GAINES L. COOKE of Grenada, McKAMY SMITH of Jackson, JOHN W. WALLER of Monticello, HARRY SCHMIDT of Biloxi, THOMAS B. WHITEHEAD of Columbia, FRANK L. LEGGETT of Bassfield, JETSON P. TATUM of Meridian, CHARLES SECREST of Houston, and WILLIAM L. WOOD of Tupelo. WILLIAM PONTIUS of Ocean Springs was elected a board director at large.

LARRY B. NEWMAN announces the opening of a urology practice at the Senatobia Community Hospital on Norfleet Drive in Senatobia.

FRANK VOGEL of Hattiesburg gave a paper on "Temporal Lobe Epilepsy and Schizophrenia-like Psychosis" at the Mental Health Institute at Cherokee, Iowa, on June 9.

THURSTON E. WILKES, II, announces the opening of his office for the practice of adult and pediatric urology at 2161 South Lamar Avenue in Oxford.

THOMAS R WILLIAMS has associated with BEN E. KITCHENS of Iuka for the general practice of medicine on Thursday and Saturdays each week at the Iuka Family Clinic, 302 Kaki Street.

JOHN WOFFORD, formerly of Greenwood, has accepted a position as medical consultant at the Mississippi Methodist Rehabilitation Center in Jackson.

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, MS 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white paper. **Brief manuscripts (about 2,500 words or 8 pages) will be given preference over longer articles.**

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly),

and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for up to four illustration engravings. More are not permitted unless voted on by two editors and extra costs must be absorbed by the author.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —The Editors.



"...Sleep that knits up the ravell'd sleeve of care..."

—WILLIAM SHAKESPEARE, *MACBETH*, ACT II, SC. 2

William Shakespeare

Insomnia

a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin[®] (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime.¹ Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information

ADAPIN[®] (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

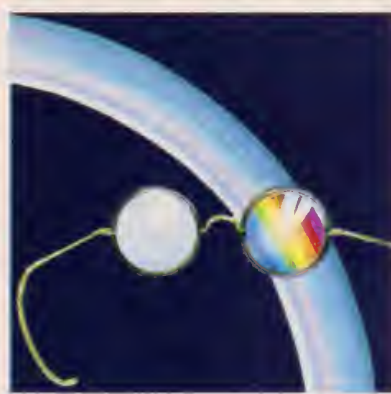
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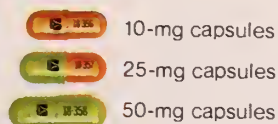


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W. D. YOUNG and Mrs. Young of Waynesboro were honored with a reception at First State Bank by the Wayne General Hospital Auxiliary. Dr. Young is the new staff surgeon at the hospital.

Medical Center Scientists Study Liver Function

A University of Mississippi Medical Center research team has shown that the insecticides mirex and kepone interfere with liver function in rats.

The scientists' preliminary research may answer basic questions about the cellular activity which governs the liver's ability to eliminate foreign chemicals.

The results of the studies of Dr. H. M. Mehendale, assistant professor of pharmacology and toxicology at UMC, and Dr. D. Desai, working with Dr. Ing K. Ho, associate professor in that department, were presented at the 173rd American Chemical Society meeting in New Orleans.

Dr. Mehendale's research has focused on the propensity of mirex and kepone to suppress the liver's normal ability to rid the body of toxic compounds. Dr. Desai investigated the impact of mirex and kepone on the enzyme system involved in the manufacture of cellular energy, the mechanism which may be responsible for the liver's activity.

First working with the contaminants polychlorinated biphenyls (PCBs) and more recently with the anti-depressant imipramine, Dr. Mehendale found that both mirex and kepone significantly reduced the liver's normal capacity to eliminate both these compounds.

"I chose first to work with the PCBs because they were being found everywhere—in milk, fish, wild animals. From my previous studies, I knew the liver can normally break down and eliminate some of the less chlorinated PCBs."

But Dr. Mehendale wanted to be sure his first findings weren't the result of a peculiar relationship between mirex and the PCBs. He selected imipramine for the next study because its chemical make up is entirely different from the PCBs.

"We knew, too, that the liver can remove imipramine under normal circumstances," he said.

From the two separate studies, Dr. Mehendale believes the effect of mirex on the liver is a general rather than specific response.

The significance of Dr. Mehendale's findings is twofold, he suggests. A reduced ability of the liver to eliminate and break down harmful substances means that these compounds can accumulate in the body at potentially toxic levels.

The chemical processes by which the liver detoxifies toxic chemicals often involves the production of more harmful forms of the toxins, metabolites.

Mirex greatly accelerates the liver's production of these metabolites, the agents which in the case of cancer-causing chemicals make these compounds carcinogenic.

"That puts the liver between a rock and a hard place when it comes to protecting the body from harmful compounds," Dr. Mehendale said.

The Mississippi research team wanted to find the mechanism by which mirex and kepone could so effect the liver's normal function and looked at the universal energy carrier adenosine triphosphate (ATP) for answers.

If the manufacture of energy is disturbed, it could hinder the movement of substances in the liver to the bile canals which remove it from the cells, the researchers speculated.

In his investigation, Dr. Desai showed that rats fed with both mirex and kepone supplements in their diet for 16 days had livers in which the enzyme $Mg^{++}ATPase$, responsible for the production of ATP, was decreased by 40 per cent.

Dr. Desai says the results of his study may support the theory that the two insecticides, and another chlorinated hydrocarbon, DDT, are harmful because they inhibit $Mg^{++}ATPase$ activity.

In vitro, however, kepone but not mirex, inhibited the enzyme activity, a discrepancy the team continues to investigate.

"The rats used in the kepone study displayed symptoms of extreme nervousness and loss of weight as well," Dr. Desai said.

The missing link in the investigation, the scientists know, is the relationship between the capacity of mirex and kepone to reduce energy production and the liver's elimination of foreign chemicals through the biliary tract.

"We suspect strongly that one is dependent on the other. Our future research will have to demonstrate that energy produced by ATP is the force needed to generate the liver's activity," Dr. Mehendale said.

Join
MPAC
Today

NEW MEMBERS

BOOTH, DONALD J., Ocean Springs. Born Rapids, WI, Mar. 12, 1935; M.D., Medical College of Wisconsin, Milwaukee, 1963; interned Wilford Hall USAF Medical Center, San Antonio, TX, one year; general and vascular surgery residency, same, 1964-69; gastroenterology fellowship, Johns Hopkins, Baltimore, MD, 1969-70; elected by Singing River Medical Society.

DUNNINGTON, WILLIAM G., Jackson. Born Cherokee, OK, Sept. 5, 1910; M.D., University of Oklahoma School of Medicine, Oklahoma City, 1934; interned University Hospitals, Oklahoma City, OK, one year; medicine residency, Jefferson Medical College, Philadelphia, Pa., 1950-52; hematology fellowship, same, 1952-53; pulmonary disease residency, Fitzsimons General Hospital, 1957-58; elected by Central Medical Society.

HOLCOMB, BARRY WAYNE, Vicksburg. Tupelo, MS, May 22, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1971; internship and medicine residency, same, 1971-74; elected by West Mississippi Medical Society.

LINDSTROM, ERIC E., Laurel. Born Helena, MT, Nov. 28, 1936; M.D., University of Maryland School of Medicine, Baltimore, 1963; Harvard School of Public Health, 1966; interned Madigan Army Medical Center, Ft. Lewis, WA, one year; aerospace medicine residency, USAF, 1965-68; ophthalmology residency, U.S. Army, 1972-75; elected by South Mississippi Medical Society.

PONTIUS, WILLIAM F., Ocean Springs. Born Tiffin, OH, Mar. 12, 1936; M.D., University of Mississippi School of Medicine, Jackson, 1965; interned Mobile General Hospital, Mobile, AL, one year; cardiovascular radiology residency, University of Florida, 1973-76; elected by Coast County Medical Society.

PUCKETT, THOMAS GLENN, Hattiesburg. Born California Nov. 13, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned Shands Hospital, University of Florida, Gainesville, 1971-72; pathology residency, University Medical Center, MS, 1972-74; pathology residency, University

of Missouri, Columbia, 1974-76; elected by South Mississippi Medical Society.

STONE, DAVID K., Jackson. Born Brookhaven, MS, Mar. 11, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned Methodist Hospital, Dallas, TX, one year; orthopedic surgery residency, University Medical Center, Jackson, MS, 1973-77; elected by Central Medical Society.

STRONG, JAMES E., JR., Jackson. Born Seattle, WA, Dec. 20, 1944; M.D., University of Arkansas; internal medicine residency, University Medical Center, Jackson, MS, 1973-75; elected by Central Medical Society.

STUBBLEFIELD, GRAVES CRAWLEY, JR., Jackson. Born Jackson, MS, Jan. 3, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1968; interned University of Iowa Hospitals, Iowa City, one year; internal medicine residency, University Medical Center, Jackson, MS, 1971-73; fellowship in hematology-oncology, same, 1973-75; elected by Central Medical Society.

POSTGRADUATE CALENDAR

FUTURE CALENDAR

Oct. 17-21, 1977

FAMILY PRACTICE REVIEW

Holiday Inn Medical Center, Jackson

Nov. 10-11, 1977

CARDIOVASCULAR REVIEW—1977

University Medical Center, Jackson

Mar. 30-Apr. 1, 1978

GASTROENTEROLOGY UPDATE

Ramada Inn Coliseum, Jackson

May 1-4, 1978

MISSISSIPPI STATE MEDICAL ASSOCIATION, JACKSON

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

MEDICAL ORGANIZATION

Medical Students Choose Primary Care Residencies

A trend which started in Mississippi some years ago has reached national proportions according to results of the 1977 National Intern and Resident Matching Program (NIRMP).

Medical students who participated in NIRMP this year chose primary care residencies almost three to one over other specialties.

Nationally, the rise represents a 42 per cent increase in the past four years.

But four years ago in Mississippi, 60 per cent of the graduating medical students at the University of Mississippi Medical Center departed from the national profile by choosing a primary care specialty, a ratio considerably above the national average at the time. The figure has stayed above 50 per cent in the years following, and last year peaked at 70 per cent.

"Traditionally, more Mississippi graduates become primary care physicians because of the nature of practice in the state," according to Dr. Carl Evers, associate medical school dean for student affairs at the Medical Center and MSMA president-elect. "The physician shortage in Mississippi has always been more acute in rural areas—places where specialists are needed least."

The factors influencing this national trend arise mostly from need, Dr. Evers said.

"Students are responding to what they've been told in the last few years about the need for more primary care physicians in Mississippi. For example, we probably have sufficient numbers of neurosurgeons, but not enough doctors who see and treat a wide range of people with a variety of illness or injury."

New curriculum shifts at the Medical Center allow more time in the primary care areas. For the first time this year, UMC junior medical students took a required three-week block in family medicine. The internal medicine block was extended to a total of 12 weeks.

As seniors next year, they'll find increased exposure to primary care by both required and elective blocks.

Internal medicine was, and still is, the big drawing card for students who want to practice general medi-

cine. When family medicine departments developed across the country, like the UMC department established in 1973, students began choosing that specialty in increasing numbers.

Of a total of approximately 280 residency slots at the Medical Center, 60 are in internal medicine, 35 in family medicine, 23 in pediatrics, and 20 in ob-gyn.

Forty-three out of this year's graduating class of 110 (39 per cent) will stay at the Medical Center for residency training—28 in primary care programs, and 15 in other specialty areas.

Dr. R. F. Triplett Heads Medical Alumni

Dr. R. Faser Triplett of Jackson was installed as 1977-1978 president of the Medical Alumni Chapter of the University of Mississippi Alumni Association at the group's 25th annual meeting.

Chapter members selected Dr. L. Stacy Davidson of Cleveland as president-elect during the business session at the Sheraton-Biloxi Motor Inn. Dr. Davidson is also chairman of the Medical Alumni Guardian Society of the University of Mississippi Foundation.

Outgoing alumni president Dr. Charles Farris, Jr., of New Orleans presided at the meeting. Dr. Berlyn Edwards of Biloxi headed the program planning committee, and Dr. Leonard Ball and Dr. Thomas Garrott, also from the Coast, were committee members.



Dr. Triplett



Dr. Davidson

UMC Holds 21st Annual Commencement



Speaker for the University of Mississippi Medical Center's 21st annual Commencement Parham Williams (center), University of Mississippi law school dean, was joined on the Commencement platform by (from left) Dr. Norman C. Nelson, UMC vice chancellor, Dr. John Lovelace of Batesville, member of the Board of Trustees, Institutions of Higher Learning, Mrs. Betty A. Williams of Columbus, also a board member, and Dr. Arthur DeRosier, Ole Miss vice chancellor for academic affairs who conferred degrees on the 303 graduating UMC students.

Dr. A. C. Guyton Is Awarded Honorary Degree

The Medical College of Wisconsin has awarded Dr. Arthur C. Guyton, University of Mississippi Medical Center physiology-biophysics chairman, an honorary Doctor of Science degree.

Chairman of the Board of Directors Carlton P. Wilson conferred the degree during the Milwaukee institution's 65th annual commencement ceremonies.

Dr. Guyton was cited for "his insights of biologic regulatory mechanisms upon which life depends, for his outstanding ability as an educator, and for his productive leadership in physiology."

He was credited with "advancing the state of our knowledge about virtually every aspect of the heart and blood vessel system" and with "expressing himself with clarity, even to beginning students, an achievement which has earned him worldwide appreciation."

"Dr. Guyton has an outstanding ability to visualize many mechanisms, including neural, humoral and hemodynamic, that contribute to the regulation of circulation in healthy and diseased states," Wilson said. "He perceived that one of the fundamental aberrations of essential hypertension is in renal regulation of body fluid volumes. The validity of this concept has catalyzed fruitful research."

The Medical Center professor is recipient of a

Presidential Citation for development of aids to the handicapped. Dr. Guyton is the author of more than 360 publications, including his *Textbook of Medical Physiology* in use in medical schools throughout the country.

UMC Conducts Pediatric Intensive Course



Dr. Phil Balaski of Laurel (left), one of five participants in a pediatric intensive course at the University of Mississippi Medical Center, evaluates course content with coordinator Dr. J. M. Montalvo, UMC professor of pediatrics. The School of Medicine and the Medical Center Division of Continuing Health Professional Education co-sponsor a series of physician intensive courses at the Medical Center with Mississippi Regional Medical Program support.

Medical Center Scientist Studies in England

A University of Mississippi Medical Center scientist is in England this month to study mycotoxins, carcinogenic compounds produced by food molds.

Dr. Wallace Hayes, UMC professor of pharmacology-toxicology, is working in the Central Veterinary Laboratory in Weybridge, England. His research is supported by a North Atlantic Treaty Organization (NATO) Senior Fellowship in Science, one of only 20 awarded internationally.

The British institution requested Dr. Hayes because of his previous contributions in the research of these naturally occurring carcinogens.

The government of Great Britain has placed a major emphasis on the study of mycotoxins since aflatoxin was discovered as the cause of the disease which killed thousands of young turkeys in the 1960's.

Dr. Hayes is participating in a survey of the entire country to determine the incidence of mycotoxins in foods harvested by man. He'll conduct laboratory studies of the compounds and give periodic seminars.

ORGANIZATION / Continued

Laetrile Is Still Unproven

The American Medical Association has reaffirmed its position that there is no scientific evidence that laetrile is effective in treating cancer.

In a statement submitted to the FDA, AMA stated that "We believe that it is clear that laetrile is not generally recognized by experts qualified to evaluate the safety and effectiveness of drugs as safe and effective. The AMA wholeheartedly supports the efforts of the Food and Drug Administration to require drugs distributed in interstate commerce to comply with the requirements of the law.

"Those who advocate the use of laetrile as a treatment for malignancies in effect exploit the victims of cancer and their families by offering unfounded representations that the patient's cancer will be cured.

"Patients who are persuaded of the effectiveness of laetrile often postpone seeking proven medical treatment which may eradicate or ameliorate the disease."

Several states have recently legalized the use of laetrile. A bill to legalize laetrile was introduced in the 1976 Mississippi Legislature but failed to gain passage.

Medical Center Hosts Rheumatology Course



Dr. Joseph A. Hull of Indianola (left) and Dr. James E. Ball of Rayville, La., were participants in the clinical rheumatology course at the University of Mississippi Medical Center. Dr. James B. Pennebaker, assistant professor of medicine, and director of the rheumatology division at UMC, was course coordinator and instructor.

UMC Honor Graduates Are Announced



Summa cum laude graduate Dr. William Arthur Schmid, Jr., of Jackson, right, received the coveted Waller S. Leathers Award as the graduating medical student with the highest four-year academic average at the University of Mississippi Medical Center's 21st annual Commencement on June 5. He will intern at University Hospital. Dr. Carl Evers, at left, is UMC School of Medicine associate dean for student affairs and president-elect of the MSMA.

Six others in the 110-member School of Medicine graduating class received their degrees with honors. Paul Chris Christu of Clinton and David Ronald Segrest of Port Gibson earned their M.D. degrees magna cum laude.

School of Medicine cum laude graduates were Steven Lee Akins of Pontotoc, George Edward McGee of Hattiesburg, Newell Bruce Robinson of Columbus, and Thomas Lamar Wiley, Jr., of Tupelo.

Liberals Are Urged To Moderate Demands

The influential and liberal *Washington Post*, commenting on President Carter's recent remarks before the United Automobile Workers annual meeting concerning delay of national health insurance, has stated in an editorial that the President's declaration that the government cannot afford to do everything was "dead right."

Said the *Post*:

"We also think it would be the final and complete ruination of liberalism—whatever that may mean anymore—if its self-professed minions refused to face up to the difficult domestic choices and just keep on asking for it all."

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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:

Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

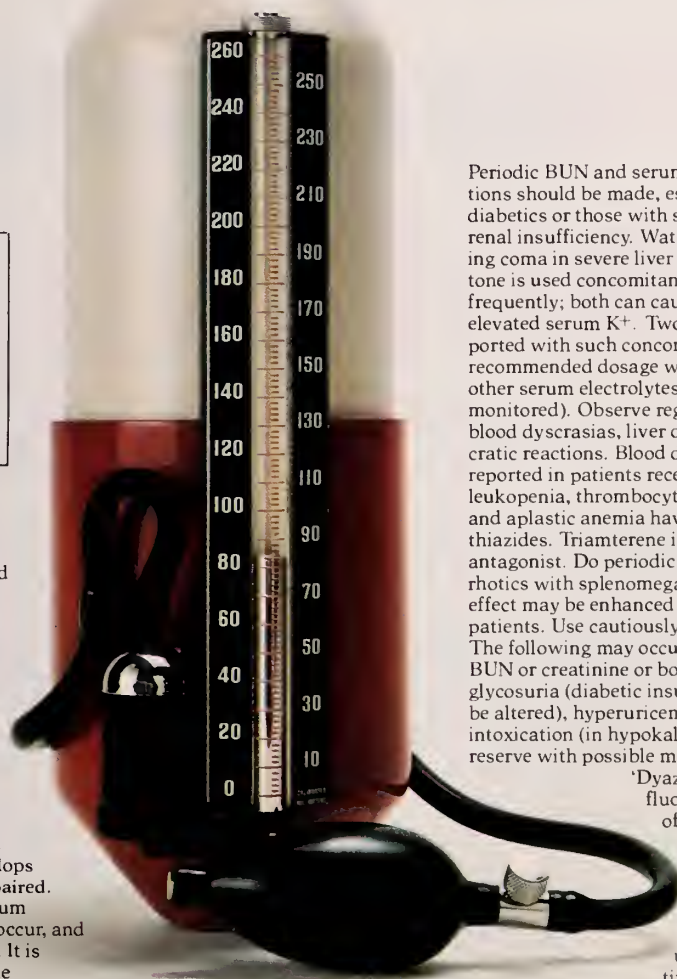
nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

**FOR LONG-TERM CONTROL
OF HYPERTENSION*
SERUM K^+ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

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New convenience
Gantanol[®] DS
sulfamethoxazole/Roche
double-strength dosage form
for acute cystitis* patients

New Gantanol® DS (sulfamethoxazole) tablets offer even greater convenience and economy for your patients with acute, nonobstructed cystitis due to susceptible strains of *E. coli*, *Klebsiella-Aerobacter*, staphylococcus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*...

- The same amount of medication, the same efficacy, with only *half* the number of tablets per day.
- Simplified dosage regimen encourages patient compliance: 2 tablets (1 Gm each) STAT—then 1 tablet B.I.D. for 10 to 14 days.
- Clinical efficacy so basic you can start cystitis therapy even before culture results are available.

- In a clinical study of 406 patients on Gantanol (sulfamethoxazole) B.I.D., close to 9 out of 10 patients achieved negative urine cultures. While Gantanol tablets were used in this study, one Gantanol DS tablet has been proved bioequivalent to two Gantanol tablets.*

Gantanol is contraindicated during pregnancy, during the nursing period, and in infants under 2 months. During therapy, maintain adequate fluid intake, perform frequent CBC's and urinalyses with careful microscopic examination.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey

and economy

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, staphylococcus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*), in the absence of obstructive uropathy or foreign bodies. Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness,

pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis). *Usual adult dosage:* 2 Gm (2 DS tabs or 4 tabs or 4 teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: DS (double strength) tablets, 1 Gm sulfamethoxazole; Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole teaspoonful.

Basic therapy with convenience and economy:

Gantanol® (sulfamethoxazole)Roche®

Basic therapy with even more convenience and economy:

Gantanol® DS (sulfamethoxazole)Roche®



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Nutley, New Jersey 07110

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(Warning: May be habit-forming);
and acetaminophen 300 mg.



Wellcome

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Asked the *Post* in an editorial that will have impact in the nation's capital:

"Is the intervention of government in people's lives, even for a benign purpose, always so benign in the way it works? Have we not learned that there can be a streak of ugly authoritarianism in even the most well-intended government programs? Can liberals afford to be as contemptuous as they traditionally have been of those who regard inflation as the principal public enemy?"

The editorial said these are questions serious-minded Democrats should be thinking about now—"not whether it is illiberal of Jimmy Carter to have delayed the prospective introduction of national health insurance until early in 1978."

Mississippi Thoracic Society Names Officers



"*Perspective on Pulmonary Medicine—1977*" was the theme of the recent annual meeting-seminar of the Mississippi Thoracic Society, the medical section of the Mississippi Lung Association. Program participants and newly elected MTS officers included: Dr. Richard T. Furr (seated left) of Ocean Springs, president; guest consultant Dr. Thomas S. Moulding, University of Colorado and Director, TB Training Program, National Jewish Hospital, Denver; (standing) Dr. Walter Treadwell, MTS past-president; Dr. Dwight Keady, secretary; and Dr. Joe Norman, vice-president, all of Jackson.

The Sex Revolution Is Here

The so-called sexual revolution of the past 10 to 15 years is real, America's doctors report.

Two-thirds of primary care physicians responding to a recent American Medical Association poll de-

clare that the sexual revolution has been "markedly reflected" in their day-to-day office practice.

The doctors report an increase in requests for birth control information, more requests for abortion information, more incidence of venereal disease, and more requests from patients for help with sexual problems.

Doctors polled included general and family practitioners, internists, obstetricians-gynecologists, and pediatricians.

Some of the doctors reported they are seeing more sexually related infections and diseases. Many more female patients are now taking the birth control pill. More requests are being received for sterilization, and doctors are being asked about sex after heart attacks. Teenagers are less reluctant to be examined than in the past, and there are more births to younger parents. More teenagers ask for sexual counseling.

Weekend Admissions Increase Costs

When a physician hospitalizes a patient on the weekend, the patient's hospital stay is apt to be several days longer—and more costly—than if he had been admitted during the week, according to a study by Blue Cross and Blue Shield of Michigan.

In the Plan's study on subscribers' weekend hospital admissions, it discovered that a Friday and Saturday admission for surgery—rather than a weekday admission—resulted in an average of 4.1 additional hospital days.

The study revealed that the difference in hospital stays between weekend and weekday admissions is almost entirely attributable to surgical cases. Non-surgical patients hospitalized on the weekend stayed only an additional half day more than those admitted on other days.

But patients admitted for surgery on the weekend, the study found, waited approximately 5.1 days before surgery was performed; those admitted on the remaining days of the week waited only 2.6 days. The waiting period between admission and surgery varied considerably among the 146 Michigan hospitals surveyed.

The average cost per case for Friday admissions was \$1,318 and for Saturday admissions was \$1,378. For weekday admissions it was only \$1,138—a savings of between \$180 and \$239 per case.

Justice Burger Calls For Simpler Justice

Chief Justice Warren Burger has suggested that the legal process needs more simplicity in resolving minor disputes or it may be on its way to being "overrun by hordes of lawyers hungry as locusts and brigades of judges never before contemplated."

Addressing a National Conference on Minor Disputes Resolution sponsored by the American Bar Association, the nation's Chief Justice suggested no-fault insurance and arbitration as possible systems to simplify an overcomplicated judicial system. Burger termed it "possible" that lawyers and judges, "aided and abetted by the inherently litigious nature of Americans" have tended to "cast all disputes into a legal framework that only legally trained professionals can deal with in traditional legal ways."

He stated that he rejected "the notion" that "ordinary people want black-robed judges, well-dressed lawyers and fine paneled courtrooms to solve their disputes," saying "people with problems, like people with pains, want relief and they want it quickly and inexpensively as possible."

Dr. James O. Gilmore Is Honored



The city of Oxford, Lafayette County and the county medical society honored Dr. James O. Gilmore of Oxford, president of the Mississippi State Medical Association, and Mrs. Gilmore with a reception at City Hall. Mayor John Leslie, at left, presented a framed proclamation in honor of the day to Dr. Gilmore, center. At right is Dr. Jim Bruce.

Emergency Medicine Course Set

Update 77—Techniques in Emergency Medicine, will be held Aug. 19-20, 1977, at Kahler Plaza Hotel in Birmingham, AL. The course is sponsored by the Alabama Chapter, American College of Emergency Physicians.

For information wrote: Dr. John Hard, Chairman-Registration, P.O. Box 2564, Birmingham, AL 35202.

SBH Suit Is Argued in Court

Federal District Judge Walter Nixon has taken under advisement a motion by MSMA and other defendants to dismiss Governor Cliff Finch's lawsuit concerning the Mississippi State Board of Health.

In a hearing conducted in Federal District Court in Biloxi on June 1, MSMA attorneys, James K. Child and J. Ray McNamara, attorneys for the Mississippi Nurses Association and Mississippi Pharmaceutical Association, and Attorney General A. F. Summer argued for dismissal of Governor Finch's suit. Another defendant in the suit, the Mississippi Optometric Association represented by Senator Nap Cassibry, agreed with the governor's suit and asked to be dismissed from the proceedings.

Representing the governor at the hearing were Professor George Cockran, an Ole Miss Law School faculty member, and attorneys Alvin Binder, Bob Perry and Herman Glazier, all of whom are members of the governor's staff.

Press reports about the hearing have appeared in numerous Mississippi newspapers and all have generally identified the governor's suit as a move to repay political debts and to attack the power of the Mississippi Legislature over the state's chief executive officer.

Some interesting events have flowed from the governor's suit. Still unanswered is where funds are coming from to finance the suit. Recent stories in a Jackson newspaper have indicated that the governor's office has used federal funds to finance staff activities unconnected with the purpose of the funds.

A number of Ole Miss law students have related that they have conducted research projects in connection with the governor's suit. Additionally, the governor has now placed on record statements from two physicians connected with a federally funded health project that they were going to sue him if he didn't place blacks on the State Board of Health.

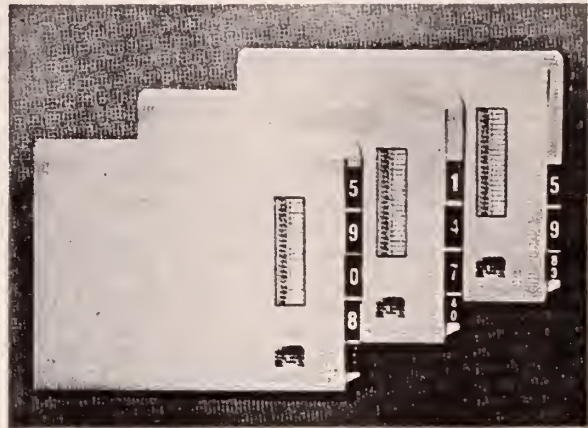
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ALABAMA: Emergency Physician: Full time, \$70,-000+ per year, fee for service, group health insurance, malpractice paid, funded continuing education, 305 bed regional medical center plus 350 bed community hospital and 100 bed community hospital with inhouse and outpatient responsibility. New ED facilities within 18 months with interns and resident teaching. Contact: Medical Director, P.O. BOX 9639, Marina del Rey, CA 90291, Phone (213) 822-1312.

OB/GYN Physician, Board Certified or Board Eligible, wanted to work in outpatient abortion and family planning clinic located in Baton Rouge, Louisiana. Louisiana Medical License is required. Send curriculum vitae to: Hillcrest Clinic Executive Business Office, 7603 Georgia Ave., N.W., Washington, D.C. 20012. Attention: Michael A. Jackson, M.D.

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IN CONCLUSION

A novel program in economic education whereby 11th grade students leave their classrooms and learn about the American economic system at on-site locations is in its second year at Meridian. The program is known as "Project Business." During the 1976-77 school year, 64 students each spent a total of 60 hours "on location" in 15 Meridian industries. They do not receive "pay" for the educational experience but are credited with a one-half unit in their economics course. The group scored very high in economic understanding at the end of the year.

A special television program examining some startling facts about females and cigarette smoking will be broadcast during the second week in August in many areas of the country. The program is part of MEDIX, a weekly half-hour series dealing with medicine and health. "The Feminine Mistake" was produced in cooperation with the American Cancer Society. While the number of male smokers of all ages had steadily decreased, more teenage girls and young women are smoking than ever before. MEDIX is sponsored nationwide by Burroughs Wellcome Co.

The Consumer Price Index for ethical pharmaceuticals rose 4.3 per cent -- less than half the rate of increase of all medical care, 9.5 per cent -- during 1976. Consumer prices in general, as measured by the Bureau of Labor Statistics, rose 5.8 per cent. Consumers paid more for every therapeutic group of drugs. The largest increase -- nearly 11 per cent -- was registered by sedatives, a jump attributed largely to the cost of imported narcotics. The smallest increase was recorded by anti-infectives, less than 2 per cent.

The AMA told the House Commerce Subcommittee on Oversight and Investigations that a second opinion on surgery "is just that and nothing more -- an opinion which is, by definition, subjective." AMA said second opinions may be embraced by insurance companies and the government "as an arbitrary device to ration medical care," but "they are not of themselves a scientifically sound or medically valid method of determining the medical necessity of any procedure." Subcommittee issued a report last year implying there are many thousands of deaths due to unnecessary surgery.

"Keep 'em nibbling. Measure drinks. Don't rush refills." These are among the tips on responsible hosting contained in a packet prepared by the Wisconsin Association on Alcohol and Other Drug Abuse, Wisc. State Division of Mental Hygiene and Wisc. Clearinghouse. Booklet gives suggestions on planning a party including food recipes and ideas for nonalcoholic beverages. It also outlines the responsibility of the host to create a party environment which discourages overindulgence in drinking and relieves nondrinkers of pressure to drink.

LIBRARY

26 1977

NEW YORK ACADEMY
OF MEDICINE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morgani*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (Federal Register, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprolthrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight	Dose—every 12 hours	
	Teaspoonfuls	Tablets
lbs		
20	1 teasp. (5 ml)	½ tablet
40	2 teasp. (10 ml)	1 tablet
60	3 teasp. (15 ml)	1½ tablets
80	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
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Please see back cover.

Her next attack of cystitis may require

the BactrimTM

3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

August 1977

BALCONY

Journal of the
State Medical
Association

Mississippi



Contents:

Complete Proceedings
of the 109th
Annual Session
of the MSMA

Annual Publication
of the Association's
Constitution and
By-Laws

A character all its own.



Valium (diazepam) is a benzodiazepine with a character all its own.

Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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2-mg, 5-mg, 10-mg scored tablets
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tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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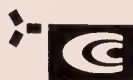
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References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly),

and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

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Volume XVIII

Number 8

August 1977



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (Publication No. 284800) is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$15.00 per annum; \$2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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THIS MONTH

- The President Speaking **224**

Because of marked increases in the cost of printing the JOURNAL MSMA, your publication committee has again elected to limit this edition to the transactions of the annual session and changes in the constitution and by-laws, together with regular features. This is a common practice in other state journals.—WMD

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70-37

**Mississippi Council of
Coca-Cola Bottlers**

Blood Banks Meeting Set for Jackson

The South Central Association of Blood Banks will hold its 20th Annual Meeting, Feb. 21-24, 1978, at the Holiday Inn Downtown in Jackson, Mississippi.

For further information, contact Marti Ginest, Executive Secretary, 4300 North Lamar Boulevard, Austin, TX 78756.

Medical Center Announces Faculty Promotions

Two associate professors who became full professors are among 13 centerwide and School of Medicine faculty promoted this summer at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor and medical school dean, announced the promotions following approval of the Board of Trustees, Institutions of Higher Learning.

Promoted to professor are Dr. Robert E. McCaa, physiology and biophysics, and Dr. Dennis J. O'Callaghan, microbiology. Dr. McCaa has been on the UMC faculty since 1967, and Dr. O'Callaghan since 1971.

Additionally, Dr. Elgene G. Mainous, professor of maxillofacial surgery and department chairman in the School of Dentistry, has been named professor of surgery (oral surgery) and chief of the division in the UMC School of Medicine.

Moving up to associate professor in the medical school are Dr. Benjamin F. Banahan, family medicine; Dr. John E. Rawson, pediatrics; and Dr. Fred J. Oelshlegel, preventive medicine.


Medical school faculty promoted to assistant professor are Dr. Jeffery A. Kelly, psychiatry and human behavior (psychology); Dr. Marie A. Mastria, psychiatry and human behavior (psychology); Dr. Bruce Parks Jr., pediatrics (pharmacology); and Dr. Deidre Phillips, family medicine.

Dr. David B. Young has been promoted to associate professor of physiology and biophysics on the Medical Center faculty. Centerwide faculty moving up to assistant professor are Dr. Thomas Edwin Jackson, physiology and biophysics, and Dr. Norman Francis Capra and Dr. William Davenport, anatomy.

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*Czapek EE: JAMA 235:636, 1976.

EMPIRIN[®] COMPOUND with CODEINE

Contraindications: Hypersensitivity to aspirin, phenacetin, caffeine or codeine
Warnings: See Warnings below.

Precautions: **Allergic:** Precautions should be taken in administering salicylates to patients with active peptic ulcers and those with known allergies; patients with nasal polyps are especially likely to be hypersensitive to the medication. SEE ADDITIONAL PRECAUTIONS BELOW.

Adverse Reactions: Most frequent adverse reactions are listed below. Some patients taking salicylates develop nausea and vomiting. Hypersensitivity may be manifested by skin rash or anaphylactic reaction. With these exceptions, most side effects occur after repeated administration of large doses; include headache, vertigo, ringing in ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin.

Phenacetin side effects usually result from overdosage. Cyanosis, acute hemolytic anemia, skin lesions, and fever may appear with toxic doses. Continued abuse may lead to renal damage.

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Contraindications: Hypersensitivity to acetaminophen or codeine.

WARNINGS, PRECAUTIONS, ADVERSE REACTIONS AND DRUG INTERACTIONS COMMON TO BOTH PRODUCTS

Warnings: **Drug dependence.** Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients. Caution patients that these products may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

Precautions: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritis.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.



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TABLETS, 20 mg.

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose, Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose, Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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NEWSLETTER

August 1977

Dear Doctor:

A study of 24,000 medical malpractice claims sponsored by National Association of Insurance Commissioners has made new major findings! Specialties play only a minor role in how many claims there will be; more important factors are the type of illness and the medical treatment selected. Mistakes in diagnosis together with planning and providing treatment make up ninety-five per cent of all claims reviewed.

Seventy-nine per cent of all claims-related injuries occurred in hospitals, sixteen per cent in physicians' offices and eleven per cent in outpatient clinics, a patient's home and nursing homes, and the most common source of claims involved accidents, digestive, urinary tract, bone and muscle diseases and childbirth complications.

Number of physicians certified in "primary care" specialties of internal medicine, pediatrics, and family practice has increased strikingly in the last 10 years, according to an American College of Surgeons Bulletin report on trends in specialty certification. Report noted that 1,332 board certificates issued in 1966 were in primary care specialties. In 1976 number was 7,368.

Americans spend a lot of money on health care, but they spend a lot more on some other things -- recreation, alcohol, tobacco and personal grooming -- for instance. A recent JAMA article gives these figures for spending in 1975: recreation, 66 billion; alcohol, 24.68 billion; tobacco, 14.8 billion; and personal grooming, 14.27 billion, a total of \$119.75 billion. Health care spending was \$86.43 billion.

The National Safety Council in 1973-74 claimed that the 55 mile per hour speed limit saved 5,600 lives. It estimated that if drunken driving were controlled, one-half of the fatalities could be eliminated. If everyone wore seat belts, an estimated 25 per cent of annual fatalities could be avoided, according to the National Safety Council.

The Journal MSMA has received two more awards during the past few months. The Mississippi Lung Association presented a special certificate to the Journal MSMA as recipient of its Medical Journalistic Support award. In national competition in the Sandoz Pharmaceuticals' State Medical Journals Awards programs, JMSMA placed third.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Allergies to Insect Stings Are Discussed

It is estimated that eight in a 1,000 persons are allergic to insects and that four of these eight are severely sensitive. In these individuals a generalized systemic reaction can result in death in 10 to 15 minutes, according to a State Board of Health report.

Primarily, members of the Hymenoptera order—bees, yellow jackets, hornets, wasps, and ants—are responsible for the more serious problems.

The following is a discussion of the recognition, treatment, management and prevention of generalized systemic reaction to an insect sting.

Symptoms of generalized systemic reaction can range from mild to severe or a reaction can be delayed, presenting as a serum sickness-like illness. It is the immediate reaction, however, that presents the physician with a medical emergency. A slight systemic reaction with symptoms of generalized urticaria, itching, malaise, and anxiety should not be ignored. Physicians must view these symptoms with the realization that the next sting may be far more serious, even life-threatening.

A moderate systemic reaction may exhibit any of the above symptoms and two or more of the fol-

lowing: 1) constriction of throat or chest, 2) abdominal pain, nausea, vomiting, 3) dizziness, 4) wheezing, and 5) generalized edema.

A severe systemic reaction may include any of these symptoms and two or more of the following: 1) labored breathing, 2) difficulty in swallowing, hoarseness, or thickened speech, 3) weakness, 4) confusion, and 5) a feeling of impending disaster.

Anaphylactic reaction would exhibit any of these symptoms and two or more of the following: 1) lowered blood pressure, 2) cyanosis, 3) collapse, and 4) incontinence and unconsciousness.

The most important step in treatment is the immediate subcutaneous injection of 0.2 to 0.5 ml of epinephrine (1:1,000) for an adult and no more than 0.3 ml for a child. If possible, a tourniquet should be applied above the sting site. Following the initial epinephrine injection intramuscular antihistamines-diphenhydramine hydrochloride, 0.5 to 1.0 ml of a 50-mg/ml solution, or chlorpheniramine maleate (100 mg/ml) are indicated. Small doses of epinephrine should be given every 15-20 minutes as needed.

Oxygen should be administered to the cyanotic patient, while measures to support blood pressure and circulation are mandatory. When massive urticaria and angioedema are present, plasma expanders may be necessary to ensure adequate blood volume and cardiac output.

Unless further treatment is indicated, the patient usually recovers quickly and can even be discharged within a few hours.

Since the patient remains vulnerable and may die quickly if stung again, desensitization should begin at once. The permanence of immunity following desensitization is difficult to measure so it is recommended that the severely allergic patient should be kept on a maintenance dose indefinitely.

Additionally, the practitioner may provide an "insect sting kit" to the severely allergic patient. Ideally, the kit should contain a preloaded syringe of epinephrine, a tourniquet, several antihistamine tablets, and simple instructions on the use of the contents. If the epinephrine turns brown, it should be replaced. The wearing of a medical tag or bracelet is strongly recommended.

If the following rules are followed, the potential for a severe insect sting will be reduced.

- Have Hymenoptera nests periodically destroyed while still manageable around the home and yard.
- Do not go barefoot or wear sandals outdoors from April to October.
- Do not wear bright, flowery clothing. Bright colors

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BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg/kg/day in rabbits and 10 mg/kg/day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.


Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG 
A division of Pfizer Pharmaceuticals
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Antivert[®]/25 
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New convenience
Gantanol[®] DS
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for acute cystitis* patients

- New Gantanol® DS (sulfamethoxazole) tablets offer even greater convenience and economy for your patients with acute, nonobstructed cystitis due to susceptible strains of *E. coli*, *Klebsiella-Aerobacter*, staphylococcus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*...
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 - Clinical efficacy so basic you can start cystitis therapy even before culture results are available.

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Gantanol is contraindicated during pregnancy, during the nursing period, and in infants under 2 months. During therapy, maintain adequate fluid intake, perform frequent CBC's and urinalyses with careful microscopic examination.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

and economy

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, staphylococcus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*), in the absence of obstructive uropathy or foreign bodies. Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness,

pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis). *Usual adult dosage:* 2 Gm (2 DS tabs or 4 tabs or 4 teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.) 20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: DS (double strength) tablets, 1 Gm sulfamethoxazole; Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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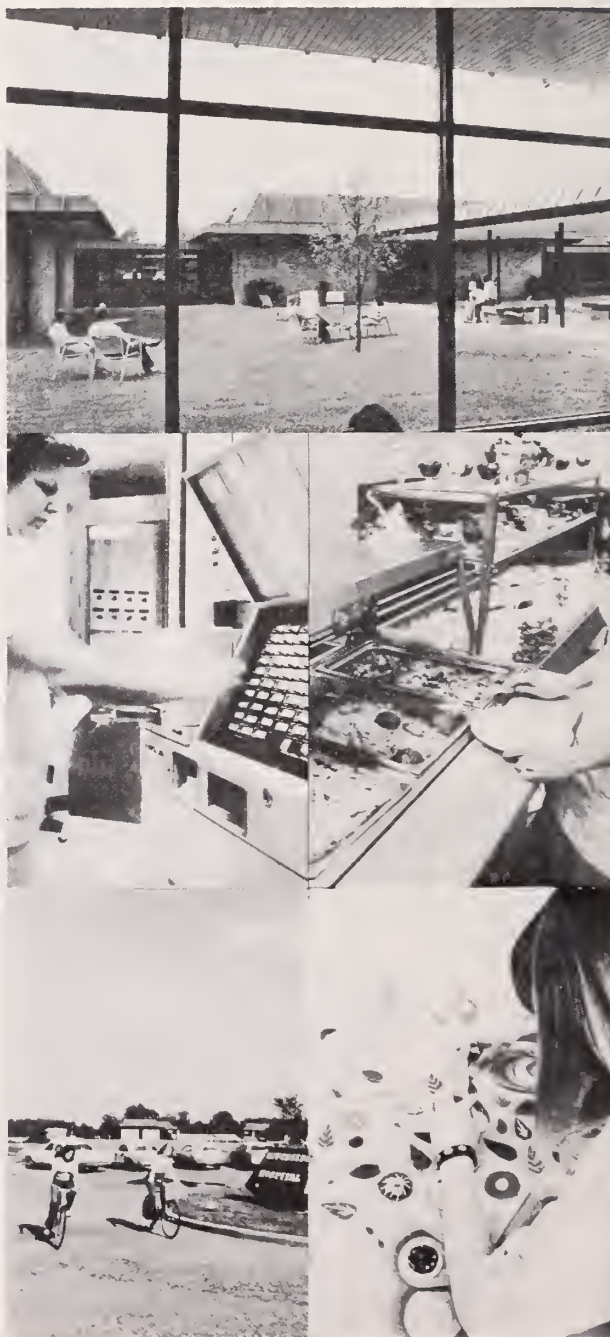
The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

For additional information contact: John R. Reedy,
Executive Director.

Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030



DATELINE

Motorcyclists Should Washington, DC - Motorcycle fatalities have risen 20 per
Wear Those Helmets cent in states that have repealed laws requiring motor-
cyclists to wear helmets, according to preliminary data
from National Highway Traffic Safety Administration. The agency said there had
been no increase in motorcycle fatalities in states that haven't repealed the law.
Repeal measures have been passed in Alaska, Arizona, Connecticut, Iowa, Kansas,
Louisiana, Oklahoma, Rhode Island and South Dakota.

Has NHI Worked in Chicago, IL - The National Center for Health Services
Canada? Research contracted with the University of Chicago to
study changes in Canada due to NHI. Study showed morbidity
and mortality statistics appear unchanged, the federal government does "not appear
to be able to contain health costs under universal health insurance," as far as
could be determined, quality of care remains unchanged and maldistribution of MDs
continues -- but access to care seems to have improved at all income levels.

Hysterectomy Is Washington, DC - Two medical professors have informed
Number One Operation House Commerce oversight committee, headed by Rep. John
Moss (D., CA) that hysterectomies have become the nation's
leading operation (725,000 in 1975). The Yale and Harvard faculty members said
hysterectomies rose by "staggering" 25 per cent between 1970 and 1975, are per-
formed too frequently, and that rate of hysterectomies is higher among patients of
surgeons who collect individual fees than those in prepaid health plans.

Errors in Washington, DC - A recent Department of H.E.W. statistical
Welfare report indicated that Mississippi had one of the highest
error rates in determining eligibility for Aid to Families
with Dependent Children of any state in the nation during 1976. 24.2 per cent of
the total cases processed by the Mississippi Department of Public Welfare in July-
December, 1976 had errors concerning eligibility or payment. In 1973 the base
year for HEW reports Mississippi had an error rate of 17.5 per cent.

Nursing Practice Jackson, MS - The Mississippi Board of Nursing has extended
Matters the date for receiving credentials and protocol from re-
gistered nurses functioning in an expanded role to Sept. 1,
1977. MSMA and the Mississippi Nurses Association have supported the physician-
registered nurse joint practice expanded R.N. role. On another matter the Board of
Nursing has voted to endorse registered nurses from Canada who have written and
passed the Canadian Nurses Association Testing Service examination.

Pediatric Orthopedic Conference Slated

A pediatric orthopedic conference is set for Oct. 20-22, 1977, at the Sheraton Hotel in Gatlinburg, TN.

The purpose of the 1977 conference is to disseminate current information and review some of the basic precepts of pediatric orthopedics to the family practitioner, the pediatrician, and the orthopedic surgeon. The subject matter will include all aspects of pediatric orthopedics from sports medicine to neurological problems. Etiology, diagnosis, pathology, treatment and prognosis of various entities will be discussed by local faculty and guest faculty.

For more information contact: Dr. Harvey L. Goodman, director, Continuing Medical Education, University of Tennessee Center for the Health Sciences, 1924 Alcoa Highway, Knoxville, TN 37920.

UMC Adds New Faculty Members

Two assistant professors and an instructor have been named to the faculty at the University of Mississippi School of Medicine.

They are Dr. Bryan Barksdale, assistant professor

of medicine; Dr. Michel Aaron Douglas, instructor in medicine (neurology); and Dr. Leon C. Parks, assistant professor of surgery.

Their appointments were announced by UMC Vice Chancellor Dr. Norman C. Nelson following approval of the Board of Trustees, Institutions of Higher Learning.

Dr. Barksdale, a Jackson native, earned the B.S. degree in 1968 at the University of Mississippi and the M.D. in 1972 at the Medical Center. He did his internship at Duke University, Durham, NC, and his residency at UMC.

A graduate of Rice University, Dr. Douglas received the M.D. degree from the University of Texas Southwestern Medical School at Dallas in 1973. He took his internship and residency at the Mississippi Medical Center.

Dr. Parks attended Colorado School of Mines, Golden, CO, and George Washington University, Washington, DC. He earned the M.D. in 1966 at the University of Colorado School of Medicine in Boulder.

Dr. Parks took his internship, residency and post-doctoral training at Johns Hopkins Hospital in Baltimore, MD, where he has been an instructor in surgery.

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Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal* contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

RC/RD PD-JA 1699-2-P (8-76)

When it's pinworms, treat the family



Povan[®] (pyrvinium pamoate)

- over 17 years of proved clinical effectiveness and safety
- no measurable absorption from the GI tract—minimal systemic side effects
- one dose—one time—that's all that's usually required
- two dosage forms: Tablets and Suspension—suitable for the entire family

Povan—there's a form for every member of the family.

PARKE-DAVIS

Think you know all about asthma?

Then you should know all about TEDRAL.

It provides —

- ☐ rapid symptomatic relief, as well as prophylaxis
- ☐ β -ADRENERGIC ACTION THAT RELAXES BRONCHIAL SMOOTH MUSCLE
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- ☐ synergistic action of ephedrine and theophylline for effective and prolonged bronchodilation
- ☐ dosage forms to meet individual patient needs

For asthma management...

Tedral[®]/Tedral SA[®]/Tedral Elixir[®]

Each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital

Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer), and 25 mg phenobarbital in the immediate release layer.

Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

SUSTAINED ACTION



WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

T-GP-74-B/W

CAUTION: Federal law prohibits dispensing Tedral SA without prescription.

Description. Tedral; each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Tedral SA: each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital in the immediate release layer.

Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

Tedral Elixir is convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients; porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to *one-quarter* Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

STORE BETWEEN 59° and 86°F (15° and 30°C).

Full information is available on request.

Family Medicine Review Is Scheduled

The eighth Family Medicine Review, Session I, is set for Oct. 2-7, 1977. Session II is scheduled for Oct. 23-28, 1977, at the Hyatt Regency Lexington, Lexington, KY.

The review is approved for 50 hours of AAFP credit and Category I, AMA Physician's Recognition Award Credit. Registration fee is \$295.00.

For further information, contact: Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

Ob-Gyn Group Will Meet in Biloxi

The Central Association of Obstetricians and Gynecologists will meet at The Broadwater Beach Hotel in Biloxi, MS on Oct. 6-8, 1977.

For more information, write David G. Anderson, M.D., secretary-treasurer, Women's Hospital, University of Michigan Medical Center, Ann Arbor, MI 48109.

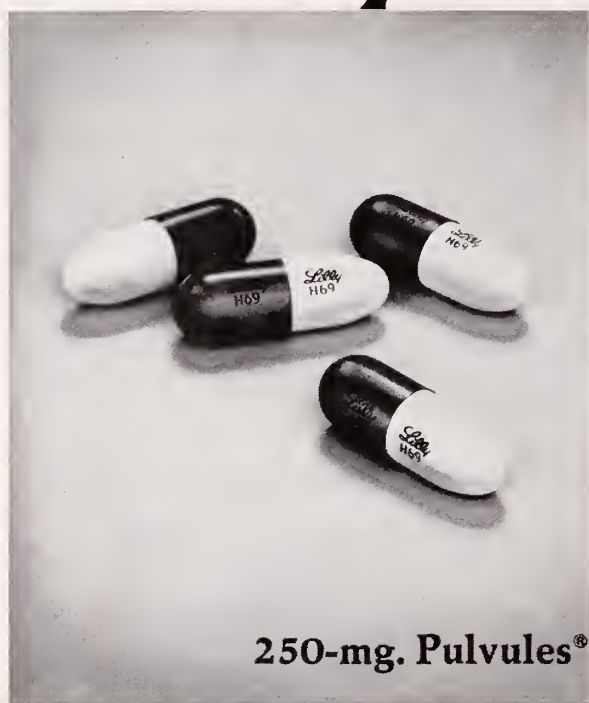
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AMA's Regional CME Tan-Tar-A Golf and Tennis Resort Osage Beach, Missouri Sept. 16-18, 1977

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Proceedings of the House of Delegates

109th Annual Session

May 2-5, 1977

Biloxi, Mississippi

THE 74TH ANNUAL SESSION of the House of Delegates was convened during the 109th Annual Session of the Mississippi State Medical Association, in pursuance of lawful notice given, on May 2, 1977, in the Top of the Sheraton, Sheraton-Biloxi, Biloxi, Mississippi, at 9:00 o'clock in the morning by Dr. James O. Gilmore of Oxford, president-elect. The invocation was spoken by the Reverend Richard Summers of Gulfport.

After extending greetings, Dr. Gilmore presented the vice speaker, Dr. R. Faser Triplett of Jackson, and the speaker, Dr. C. D. Taylor of Pass Christian, who assumed the chair. Dr. J. Elmer Nix of Jackson, chairman of the Reference Committee on Credentials, reported the presence of a quorum of 104 registered and seated delegates in accordance with Section 3, Chapter V, By-Laws of the association.

Announcement of the Reference Committees

Reports of Officers, Board of Trustees and Councils

Virginia S. Tolbert, Ruleville, Chairman

William H. Preston, Jr., Booneville

Ellis M. Moffitt, Jackson

W. Moncure Dabney, Crystal Springs

James W. Holmes, Wiggins

Constitution and By-Laws

W. Lamar Weems, Jackson, Chairman

Mary J. Ward, Corinth

Louis C. Lehmann, Natchez

Credentials

J. Elmer Nix, Jackson, Chairman

William C. Gates, Columbus

A. K. Martinolich, Bay St. Louis

Rules and Order of Business

Stanley A. Hill, Corinth, Chairman

Tom H. Mitchell, Vicksburg

Charles N. Floyd, Gulfport

Appointment of Tellers and

Sergeants-at-Arms

The three vice presidents were designated as

tellers. They are: J. Edward Hill of Hollandale, Hardy Woodbridge of Jackson, and Brantley Pace of Monticello. Dr. Pace was absent so the chair asked Dr. William Gillespie of Meridian to serve in his place.

Report of the Reference Committee on Rules and Order of Business

To assist the speaker and vice speaker in the orderly conduct of the proceedings of this House of Delegates, your Reference Committee on Rules and Order of Business makes the following recommendations:

Conduct of Business. Under the by-laws, the business of the House must be conducted according to *Sturgis Standard Code of Parliamentary Procedure*, and the speaker and vice speaker should prescribe the order of business as set out in the by-laws. To insure proper recording of the transactions, all delegates recognized should identify themselves. Except for distinguished visitors and those having official capacity in the association, unanimous consent should be obtained for extending the privilege of the floor to nonmembers of the House of Delegates. The report of the Reference Committee on Credentials should constitute the formal and official roll call of the House.

Reference Committees. The purpose of reference committees is for affording all members of the association an opportunity to discuss their views on matters under consideration by the House of Delegates.

Reports. All reports and resolutions should be referred to the appropriate reference committee by the chair, the only exception being those which are of such a nature as to require no further consideration and are therefore ready for decision by vote of this House. Reports in the Delegates folders are considered to have been formally presented and referred to appropriate reference committees by the chair. Debate should be reserved on all such presentations until such time as the reference committees conduct

HOUSE OF DELEGATES / Continued

formal hearings and when they report to the House.

Resolutions. To avoid burdensome tasks upon the reference committees and to insure that all members have adequate opportunity to discuss their views, the House should permit no introduction of resolutions after the present meeting except for (1) matters of an emergency nature, the validity of such emergency to be determined by majority vote, (2) matters relating to a scientific section of scientific work, and (3) proposed amendments to the constitution and by-laws which would then lie on the table for one year.

The report of the reference committee was adopted.

Adoption of the Transactions

On motion by Dr. Stanley A. Hill of Corinth, and severally seconded, the Transactions of the 73rd Annual Session of the House of Delegates, 108th Annual Session of the Association, May 3-6, 1976, published in Volume XVII, Number 8, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, August 1976 were adopted.

Remarks of the Speaker

Dr. C. D. Taylor, Jr.: Your Speaker appreciates the indulgence and direction of the House of Delegates in allowing for a brief format at this opening session. As you know we mailed most of the reports to you that are normally read at this time.

Your Speaker feels that he should reciprocate and in so doing he will only say that all will be accorded an opportunity to speak in accordance with "Sturgis Standard Code of Parliamentary Procedure." Let us proceed with the business of this 109th Annual Session.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee received the remarks of our speaker, Dr. C. D. Taylor, and we commend our speaker and vice speaker, Dr. R. Faser Triplett, for the outstanding manner in which they have conducted the business of the House.

The report of the reference committee was adopted.

Presentation of Distinguished Guests

The speaker presented the following distinguished guests:

Leonard Roberts and Michael Long, UMC stu-

dent delegates

Dr. Charles Farris, President, Ole Miss Medical Alumni, New Orleans, LA

Ms. Barbara Eich, AMA, Chicago, IL

Mr. Chan Moseley, president, Blue Cross-Blue Shield of Mississippi

Mr. Aaron Johnston, Blue Cross-Blue Shield of Mississippi

Mr. Will Lowery, assistant director, Mississippi Medicaid Commission

Dr. Norman Nelson, Dean, University Medical Center

Dr. Alton Cobb, State Health Officer

Members of the Press

Announcement of the Nominating Committee

Following a recess for caucuses by association districts, the Nominating Committee was announced:

J. V. Ferguson, Greenwood, District 1

W. J. Burnett, Oxford, District 2

William H. Preston, Booneville, District 3

W. B. Hunt, Grenada, District 4

Tom H. Mitchell, Vicksburg, District 5

William M. Hilbun, Jr., Meridian, District 6

Gerald P. Gable, Hattiesburg, District 7

David Steckler, Natchez, District 8

Charles N. Floyd, Gulfport, District 9

Dr. Gable was elected chairman of the committee which conducted an open meeting on May 4, 1977, and posted the nominations for the information of all members in addition to submitting a written report of nominations to the House of Delegates.

Address of the President

The speaker declared the House in open session and announced that the president, Dr. Lyne S. Gamble of Greenville, was ill and a patient in the University Hospital in Jackson. He asked and was granted the permission of the House to allow Dr. Gamble's son, Dr. Hugh Gamble of Jackson, to read his father's address. That address has been published separately in Volume VIII, Number 7, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, July 1977.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee received the address of our president, Dr. Lyne S. Gamble of Greenville, and we especially commend him for such unparalleled service in our behalf during what has been a difficult and trying year. Dr. Gamble's remarks

clearly reflect his vast knowledge of the many issues which face our profession and his very evident concern for the future, honor and integrity of our association. We also want to extend our special thanks to Dr. Hugh Gamble for delivering his father's address as a result of the untimely illness which prevented Lyne from attending this 109th Annual Session. Even though Lyne's absence was clearly felt, his spirit of love and dedication for our association and his colleagues was all-pervasive.

The report of the reference committee was adopted.

Special Address

Dr. Richard E. Palmer of Alexandria, VA, president of the American Medical Association, addressed the House of Delegates.

Reports of the Delegates to AMA

1976 AMA Annual Session. The 1976 AMA Annual Session was conducted in Dallas, June 27-July 1, 1976. Dr. Richard E. Palmer of Alexandria, VA, was installed as president. In his inaugural address Dr. Palmer noted that the federal government having made itself the "chief arbiter of what is desirable, by now has shown it is far less adept in realizing possibilities than in stimulating desires." "Some group has to be blamed and disciplined for the embarrassing gap, and in medical care, that group is the giver of care," Dr. Palmer concluded.

Restructuring of the AMA council system took place at the meeting. The House approved by-law changes establishing the size, composition and tenure for eight standing councils of the AMA. All other AMA councils will now be appointed on an ad hoc basis and carry a specific phase-out date. Enactment of the new council system was an outgrowth of the fiscal crisis in 1974 from which the AMA has extricated itself.

Debate on national health insurance highlighted various legislative proposals that came before the House. Some delegates urged that the AMA drop support for any NHI proposal, but the majority view prevailed that the AMA needed to support Medicare to stay in the NHI ballgame.

In addition to NHI, the House wrestled with a whole panoply of government programs and regulations that they called unwarranted interference in the practice of medicine. The "alphabet soup" included HSAs (health systems agencies), HMOs (health maintenance organizations) and MACs (maximum allowable cost drug formularies). On each issue, the House expressed its dissatisfaction and directed the

board to pursue ameliorative actions.

Mississippi had two items of particular interest before the House. Following up on a resolution supported by our delegates at the 1975 AMA Annual Session, the Council on Medical Service issued a report concerning the effect of Medicare/Medicaid reimbursement policies on the distribution of physicians. Our interest was with regard to the inequity between Medicare payments made in Mississippi and certain more urban populated states. The Council on Medical Service's report concluded that sufficient discrepancies existed between rural and urban fees . . . "to merit serious efforts at relief." Unfortunately, however, to our thinking the solutions offered by the council and adopted by the House of Delegates do not address the problem in a timely and adequate manner. The solutions were to: (1) emphasize UCR as the basis for physician payment; (2) urge physicians to bill their usual fee even if payors reduce the amount of payment; and (3) seek repeal of the Medicare "economic index." Parenthetically, it should be noted that there is a bill (S. 3205) before Congress which specifically proposes solutions to rural-urban fee discrepancies. The solutions are not, however, similar to the AMA solutions and the AMA is opposing their enactment.

On another matter of interest to our state, a resolution urging the AMA to study the feasibility of establishing a "patient compensation program" similar to the present Workmen's Compensation Program was favorably acted on. The resolution was adopted at our recent MSMA House of Delegates meeting.

In other actions the AMA House of Delegates:

- Acted to establish a public service program on the effect of TV violence on children.

- Requested the Joint Commission on Accreditation of Hospitals to ensure that mandatory review and audit programs do not overemphasize cost savings at the expense of quality medical care.

- Urged county and state peer review committees to "correct or refer to the appropriate disciplinary bodies" those physicians who have not met professional standards.

- Reaffirmed AMA policy that the use of extraordinary life-sustaining measures was a moral decision between patient and physician.

- Referred for study by the Board of Trustees a policy statement on mandated surgical consultations.

- Directed the Board of Trustees to study and update its policy on physicians' offices owned or

HOUSE OF DELEGATES / Continued

controlled by hospitals and in "close proximity to such hospitals."

—Opposed the use of Social Security numbers or any system of universal identifiers for patients.

—Reactivated a special committee of the House to look into appropriate techniques and avenues for polling the AMA membership on issues of concern to the medical profession.

1976 AMA Clinical Session. The 1976 AMA Clinical Session was conducted in Philadelphia, Dec. 5-8, 1976. Debate over whether the AMA should sponsor a national health insurance bill sparked the meeting. AMA president, Dr. Richard E. Palmer, strongly urged delegates not to "turn their backs" on the national health insurance debate in a speech to the House of Delegates. "If we are to offer nothing in the way of NHI legislation," Dr. Palmer said, "we run the terrible risk of getting clobbered with everything," referring to the mandatory, comprehensive Kennedy-Corman NHI bill.

After much discussion delegates voted 181-57 to continue AMA sponsorship of an NHI bill and the bill has since been introduced in the 95th Congress as S. 218 and H.R. 1818.

The House of Delegates reaffirmed its formal definition of primary care specialties turning down a strong effort to refuse to designate any field as "primary." General practice, family practice, internal medicine, pediatrics, and obstetrics-gynecology are still the AMA's choices as formal primary care specialties.

On peer review matters the House urged government indemnification for mandated health care review programs as opposed to those programs sponsored by the profession; protested the Social Security Administration's practice to reimburse for utilization review only if all hospital patients are subject to review; and opposed certain penalties against providers set up in the PSRO law. In regard to Medicare and Medicaid, delegates deplored any and all acts of fraud and called for prompt prosecution by both government and the AMA.

In other actions the AMA House of Delegates:

—Called for re-establishment of the Office of Surgeon General of the U. S. Public Health Service.

—Adopted a report outlining considerations for physicians thinking of locating offices in buildings owned or controlled by hospitals.

—Turned down an attempt by several state delegations to pass a resolution urging that rural physicians receive greater reimbursement under Medicare than under current regulations.

—Reviewed plans for a membership opinion poll with the results to be reported at the 1977 annual session.

—Adopted a report by the Council on Medical Education reviewing progress in increasing the number of family practitioners over the past 10 years. The report noted the success of recent AMA efforts in greatly increasing the number of programs in family practice.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee considered the report of our Delegates to the AMA. We wish to commend our delegates for their report and for their continued outstanding service in our behalf in the AMA House of Delegates.

The report of the reference committee was adopted.

Report of the Council on Scientific Assembly

Organization and Duties. The Council on Scientific Assembly is a constitutional body of the House of Delegates charged with the responsibility of planning the annual session of the association to include all scientific activities, programming, and the scheduling of annual session events. The council membership consists of the chairmen and secretaries of the 12 scientific sections and the secretary-treasurer of the association, a total of 25 members.

109th Annual Session. Planning and organization of the 109th Annual Session was initiated in the summer of 1976. The final session of the House of Delegates will again meet on Thursday morning and the convention will be over at noon that day. With 12 scientific sections, it was necessary to schedule several simultaneous meetings but conflicts of interest were avoided wherever possible. Three sections will meet on Sunday afternoon, thus making the first day of the annual session May 1. In some instances, the council has requested and placed essayists from various specialty societies not represented in the Scientific Assembly before section audiences. The council has applied for postgraduate credit for the Scientific Assembly from the AMA and the American Academy of Family Physicians.

We are gratified that at the present annual session, numerous specialty societies have related or concurrent meetings with us. Three medical alumni groups

have fraternal and social occasions during convention week, and various nonscientific but medically related bodies will meet during May 1-5. Added postgraduate attractions this year include a Sunday afternoon seminar on genitourinary problems and a practical course (one hour) on tonometry. We continue to believe that providing for and encouraging these related meetings increases the attractiveness of the annual session to the membership and benefits attendance. We are glad to continue support of the Auxiliary concurrent annual session, and the Auxiliary will again host the Sunday afternoon hospitality booth to greet convention goers.

The council voted to host a fellowship party on Tuesday night for MSMA members and to honor the exhibitors. The party will feature cocktails and hors doeuvres only and tickets will sell for \$6.00.

Scientific and Technical Exhibits. Your council is grateful for the participation of our scientific and technical exhibitors in this 109th Annual Session of the association. Presentations in the scientific exhibit number over 15 again this year and every technical space has been sold. We urge every member and guest to view these educational exhibits and the technical exhibits.

Headquarters Hotel. The annual session returns to the Gulf Coast and the Sheraton-Biloxi for the 1977 meeting. The facility has completed renovation of the lobby and meeting area since the 1975 convention. An added attraction to the hotel are four tennis courts and the council plans to sponsor a mixed doubles tennis tournament for MSMA members and spouses. The council is directing an extensive promotional campaign through the JOURNAL MSMA and the Blue Sheet to increase attendance at the annual meeting.

Expression of the Council. Your Council on Scientific Assembly is grateful for the support, cooperation and assistance we have received in planning the 109th Annual Session.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee received the report of the Council on Scientific Assembly and we commend the council for its painstaking work and efforts in planning this excellent 109th Annual Session.

The report of the reference committee was adopted.

Report of the Council on Medical Service

Organization and Duties. The Council on Medical Service is a constitutional body of the House of

Delegates consisting of nine members, one from each association district elected for terms of three years each. This report covers the activities of the council's several committees during the 1976-77 association year.

Committee on Nursing. The committee on nursing has continued to act as the liaison committee with the Mississippi Nurses Association and has met quarterly during the past year.

The committee has continued to work in the area of recommending standards and criteria for nurse practitioners to the Board of Health and Board of Nursing under the expanded role definition of nursing as adopted by the legislature in 1974. At this date, standards and criteria in four nursing specialties have been adopted by both boards pursuant to the committee's recommendations. Throughout its work the committee has attempted to develop standards that will assure only the utilization of highly qualified nurse practitioners in an expanded role in collaboration with one or more physicians. It is expected that the committee will continue its work in this regard for some time to come.

The committee has also continued its study of nursing education programs and sought to make recommendations attendant thereto whenever appropriate.

The committee has also adopted a position of opposing an HEW proposal that would require that all health manpower be "credentialed" or licensed on a national level rather than the existing state level basis.

Committee on Blood and Blood Banking. Pursuant to action by the House of Delegates in 1976, this committee was activated in July 1976. Commensurate with its activation the committee resolved that every effort would be made to improve the relationship between two blood collection organizations in Jackson that had often been at odds and whose problems had been aired through the media.

The committee has also adopted a policy statement to "encourage efforts to bring about an all-voluntary blood donation system and to eliminate commercialism in the acquisition of whole blood and blood components." Additionally, the committee has also recommended that one statewide blood collection program should be developed and controlled by MSMA on a regional and community basis. The committee will continue to study this possibility in future meetings.

The House of Delegates also referred to the committee a report of the Council on Legislation requesting that a policy position on legislation man-

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dating the labeling of blood be recommended to the council. The subject of mandatory blood labeling was studied in detail at the committee's December 8 meeting and it was the decision of the committee to recommend that legislation requiring the labeling of blood should be opposed because of the lack of specific positive data from the majority of the three states that have adopted such labeling laws. There was also a great deal of concern on the part of the committee that mandatory labeling might further reduce the already critical supply of available blood. In hearings before legislative committees on this subject one member of the committee testified in support of the proposal while another member testified in opposition in accordance with the committee's action.

Committee on Maternal and Child Care. This committee has continued its study of maternal deaths occurring in Mississippi. During the past year the committee completed and published its study of maternal deaths occurring in Mississippi in 1973-74. The study was published in the March 1977 issue of the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION.

The maternal mortality rate in Mississippi (maternal deaths per 10,000 live births) was 2.5 in 1973 and 3.0 in 1974. This was a considerable improvement over the 1971 and 1972 death rates which were 4.3 and 5.2 respectively and continued an overall downward trend in the maternal mortality rate in Mississippi, which was 12.0 in the first year of the committee's study in 1956. The maternal mortality rate for the United States in 1973 was 1.3 and data for 1974 was not available at the time of the committee's study.

Committee on High Risk Maternal and Newborn Care. This *ad hoc* committee composed of representatives of concerned professional groups was formed in 1975 to: (1) evaluate current patterns in the management of high risk, maternal and newborn care; (2) determine what facilities and personnel are currently available for high risk care; (3) make recommendations for the future planning of such care; and (4) establish a mechanism for the continuing evaluation of the effectiveness of planning and of patient care in the area of high risk maternal and newborn care.

During the past year the committee has conducted a survey of Mississippi hospitals to determine perinatal resources. This data will be analyzed with respect to current resources and standards and pro-

grams for regional high risk maternal and newborn services. The committee has also acted to serve as the Technical Advisory Committee to the Plan Development Committee of the Mississippi Health Systems Agency, Inc. in the subject area of high risk maternal and newborn care.

Based on action of the committee a resolution was presented to the Board of Directors of the Mississippi Health Systems Agency, Inc. at its December 1976 meeting "... urging more reasonable Medicaid payments for maternity care as a method for improving our state's maternal and infant mortality rates and preventing childbirth defects which cost the state millions of dollars for mental health and rehabilitative services. . . ." The resolution was unanimously adopted by the Board of the Mississippi Health Systems Agency, Inc.

Committee on Mental Health. The Committee on Mental Health has given attention to the increasing problem of public use and dependence on various mind-altering agents such as alcohol, marijuana, depressant drugs and amphetamines. The committee recommends the adoption of the following policy statement by the House of Delegates in this regard.

The Mississippi State Medical Association is pledged to the expansion and strengthening of programs to combat drug dependence particularly those programs directed at prevention, identification, treatment, rehabilitation and research.

Physicians are urged to closely supervise their use of central nervous system depressant drugs.

Prescribing of amphetamines and other stimulant drugs should be limited to specific, well recognized medical indications. The use of these drugs has no rational basis in the treatment of obesity.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee received the annual report of the Council on Medical Service. The activities of the council and its several committees are many and varied and are reported therein. We commend the work and activities of the council.

The report of the reference committee was adopted.

Supplemental Report A of the Council on Medical Service

Background. The Council on Medical Service has considered a number of matters which the council believes should be brought to the attention of the House of Delegates for information and/or policy

statement approval. Activities of the council's several committees during the 1976-77 association year are presented in the council's annual report to the House of Delegates.

Expanded Role for the Registered Nurse. The activities of the council's Committee on Nursing in implementing an expanded role for the registered nurse in accordance with policy of the House of Delegates are related in the council's report to the House of Delegates. For purposes of brief background, the Nursing Practice Act was amended in 1975 based on policy and conjoint action by our association and the Mississippi Nurses Association to provide for an expanded clinical role for the registered nurse under rules and regulations jointly promulgated by the nursing and medical licensing boards. Since passage of this amendment our Committee on Nursing has served with a committee of the Mississippi Nurses Association to advise and counsel the two licensing boards concerning policies and protocol for nurses functioning in an expanded role.

The council wishes to particularly bring this matter to the attention of the House of Delegates. The council believes that policies and protocol for nurses performing in an expanded role should and presently do, provide for physician participation and approval in matters pertaining to medical diagnosis and treatment. The council further believes that adequate training for the registered nurse performing in an expanded role should, and is, being stressed. The council would emphasize that physician participation and adequate training of the nurse are important aspects of the expanded role and cases where either of these important aspects are missing should be reported to the medical and nursing licensing boards.

Statewide Plan for High Risk Maternal and Newborn Care. As noted in the council's annual report to the House of Delegates concerning the council's committees' activities the Committee on High Risk Maternal and Newborn Care is proceeding to develop a statewide plan for high risk maternal and newborn care. The council believes that such a plan has been long needed in our state. The plan should address Mississippi's needs and coordinate both public and private resources.

Committee on Mental Health. The council's Committee on Mental Health has recommended the following statement of policy on drug use and abuse which the council strongly concurs with:

The Mississippi State Medical Association is pledged to the expansion and strengthening of

programs to combat drug dependence particularly those programs directed at prevention, identification, treatment, rehabilitation and research.

Physicians are urged to closely supervise their use of central nervous system depressant drugs.

Prescribing of amphetamines and other stimulant drugs should be limited to specific, well-recognized indications. The use of these drugs has no rational basis in the treatment of obesity.

Surgical Consultation Programs. During the past year the council has considered a request from an insurance company for the association's views on "surgical consultation programs." Such programs encourage (or require) a second opinion on elective surgical procedures usually from a physician on a list of "approved" surgical consultants.

The council has studied this matter and sought advice from members of the American College of Surgeons. Based on this consideration the council believes that more information on the results of surgical consultation programs is necessary before a valid judgement can be made as to the benefits, if any, of such programs. The council notes that several such programs are in recent operation in other areas of the country and believes that both the medical and economic results of such programs should be evaluated before the programs are expanded. These recommendations have been conveyed to the insurance company that requested the association's views on "surgical consultation programs."

Medicare Fees. The inequities caused by Medicare reimbursement policies both in Mississippi and between Mississippi and other states have been matters before the council and the House of Delegates for many years. These inequities have not abated and are now in fact exacerbated by the so-called "economic index factor" applied to Medicare prevailing fees. The index in effect puts a lid on any possibility of equalizing fees between low and high Medicare reimbursement areas.

The association should continue to bring this grave matter to the attention of our congressional delegation and other concerned parties. The council recommends also that the Medicare carrier for Mississippi be asked to study the effect of combining the present two Medicare reimbursement areas in our state and to advise the association in this regard. The council further recommends that the association prepare a publication for distribution in physicians' offices to describe both Medicare and Medicaid reimbursement policies and the relationship of Medicare and Medicaid reimbursement policies to usual

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professional fees charged by physicians.

Comprehensive Health Education Act. The council has considered the great need for better health education of our citizenry. The council believes that the key to reduction of mortality and morbidity rates lies in better individual health understanding and responsibility and not as many suggest in the production of more physicians, hospitals, and other health resources. The most beneficial place to start this education is with our youth.

In this regard the council has considered a model bill promulgated by the American Medical Association entitled "A Comprehensive Health Education Act." The act would require the formulation and implementation of sequential health education programs by all local school boards within a state. The council recommends that the association support enactment of this program by the Mississippi legislature.

Child Abuse Law. The council has considered reporting and investigation problems arising under the Mississippi Child Abuse Law. The council recommends that the association prepare a summary of this law for general distribution to physicians and hospitals. The council plans to continue to study methods to improve our state's Child Abuse Law.

National Health Insurance Program. The council has reviewed the "Comprehensive Health Care Insurance Act" which has been sponsored by the American Medical Association and introduced in the 95th Congress. The basic concept of this act is full health care for all persons financed by employer-employee contributions through private health insurance. Equal comprehensive benefits will be available to the poor and indigent through federal participation in the cost of insurance. To keep costs down and as a curb against over utilization individuals, excluding the indigent, will pay a 20 per cent co-insurance up to a catastrophic level at which time there would be no co-insurance requirement.

The council believes the AMA Plan deserves our concerted support. There are other national health insurance plans before the Congress such as the Kennedy-Corman/labor sponsored "Health Security Act" which would in effect socialize medicine and establish a program similar to the National Health Service of England.

Rural Health Initiative Program. The Department of HEW through the Public Health Service has established a program called the "Rural Health Initiative Program" to coordinate a number of existing

federal health programs for the purpose of developing "health care systems" for "medically underserved areas."

It has come to the council's attention that a number of local and state agencies have expressed an interest in the Rural Health Initiative program. The council feels that members of the association should be aware of this program. Goals of the Rural Health Initiative Program as stated by its sponsor are:

1. To increase the provision of primary health care services to medically underserved rural areas.
2. To identify and make maximum use of existing health care resources, by using new approaches and concepts directed at combining, coordinating, and strengthening health service delivery resources and activities through establishment of linkages between primary, secondary and tertiary care.
3. To emphasize effective project management, higher provider productivity, and movement toward economic self-sufficiency.
4. To develop mechanisms to provide better health care to the Medicaid eligible population by integrating the Medicaid eligible population into a single rural health care delivery system.
5. To attract and use non-physician providers wherever possible to extend the capacity of physician providers.
6. To integrate primary care services into a complete system of health care delivery that is financially viable, professionally attractive, and able to become self-sustaining.
7. To emphasize programs of prevention and health education to gain full utility from the medical resources available to a rural area.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

This supplemental report of the Council on Medical Service provides information on several health matters and recommends the adoption of policy statements on many issues. This is an excellent and timely report and is representative of the many issues which face medicine today.

With regard to that section of the report dealing with the expanded role for the registered nurse your committee concurs with the comments made therein, but we would also recommend that this House reaffirm its policy of assuring that RNs in the expanded role or any physician extender work only under the direct supervision of a physician and that that physician be at all times personally responsible for acts of the extender.

In discussion, Dr. Tom H. Mitchell of Vicksburg moved that the word "direct" be deleted. The motion was seconded by Dr. Lawrence W. Long of Jackson and passed.

Your council also took particular note of the activities of the Committee on High Risk Maternal and Newborn Care in developing a Mississippi plan for high risk maternal and newborn care and further urges that such a plan be adopted at the earliest possible date.

We concur with the recommendations of the council and urge their adoption.

The report of the reference committee was adopted as amended.

Report of the Council on Medical Education

MSMA CME Activities. The Council on Medical Education of the association is recognized by the American Medical Association as an accrediting body for in-state organizations and institutions providing continuing medical education programs for physicians. During the past year the council has surveyed and accredited several organizations offering CME for physicians. The council uses the "Guiding Principles for Continuing Medical Education in Medical Institutions and Organizations" which it formulated in order to:

1. assist medical staffs of medical institutions and organizations in the production of continuing medical education activities;
2. improve the educational worth and relevance of continuing medical education activities;
3. outline mechanisms for evaluating the effectiveness of continuing medical education;
4. provide a basis for the accreditation of continuing medical education activities in medical institutions and organizations; and
5. outline an organized approach for Mississippi State Medical Association's CME survey teams to use in examining the approach of each medical institution and organization medical staff to continuing medical education when such institution or organization desires accreditation of its continuing medical education program.

The following organizations and institutions are now accredited in Mississippi: MSMA Council on Scientific Assembly; Mississippi Radiological Society; Mississippi Urological Society; Mississippi Baptist Hospital; Mercy Regional Medical Center; Northwest Mississippi Regional Medical Center.

Through the leadership of the Council on Medical Education, the association now offers as a service

to its membership the accumulation of continuing medical education hours. These hours are reported annually to the member who avails himself of this service.

CME Requirement for MSMA Membership. At the 108th Annual Session of the House of Delegates, 1976, the House adopted a recommendation that "the Council on Medical Education present a detailed plan to establish continuing medical education as a condition for membership in the association for consideration by the House of Delegates at the 109th Annual Session." In pursuance of this recommendation the Council on Medical Education has prepared this report for consideration and action by the House of Delegates at the 109th Annual Session.

Proposed CME Requirements for MSMA Membership. It is proposed that Mississippi State Medical Association CME requirements parallel those for the AMA Physician Recognition Award and the American Academy of Family Practice. Members of the MSMA who have met the continuing medical education requirements of their specialty, provided they are more than or equal to the Physician Recognition Award requirements will meet the continuing medical education requirements of the Mississippi State Medical Association.

The following outlines the general requirements for the Mississippi State Medical Association CME program, to allow for lead-in time for program development by local hospitals and MSMA.

Beginning in 1979 and to be eligible for 1982 membership in the Mississippi State Medical Association, CME requirements may be fulfilled by one of the following methods:

1. obtaining the AMA Physician Recognition Award within three years;
2. any member of the Mississippi State Medical Association who has passed a recertification examination of a national board as delineated by the American Board of Specialists will be considered to have met the continuing medical education requirement for membership of the Mississippi State Medical Association for that period;
3. completing, over a three year cycle, 150 hours of continuing medical education credits of which a minimum of 60 hours shall be mandatory hours as defined and described by the Mississippi State Medical Association.

Policies of Mississippi State Medical Association relating to Item 3 in the above methods include:

1. all the hours may be obtained in any one year;

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2. extenuating circumstances preventing an individual from obtaining the required hours of continuing education will be considered by the Council on Medical Education. Circumstances should be reported within 90 days of occurrence in order for exemption to be considered.

3. of the 150 hours required under this program, at least 60 hours must be in the mandatory category as defined below; however, the total 150 hours may be earned in the mandatory category. A physician may earn as many hours in the elective category, also defined below, as he desires; but no more than 90 elective hours will be accepted toward the 150 hour requirement.

4. Definition of credit hours:

A. "Credit hour" is defined as one hour of participation in an activity.

B. Mandatory hours: (1) MSMA-approved programs; (2) Programs designated AMA Category I; (3) Programs approved for prescribed hours or other specialty societies programs which require CME hours.

C. Elective hours: Credit will be given for participation in any scientific meeting or program not approved for mandatory hours as above, as well as for personal continuing education activities such as listening to tapes or journal and library reading. Such activities will be credited on an hour-for-hour basis and must be listed as to time and title.

These requirements shall apply to all Mississippi State Medical Association members actively engaged in the diagnosis and treatment of patients, to even a limited extent. Special considerations will be given to members who do not fit in the above group; members who have extenuating circumstances such as ill health, temporary absence from practice, etc. may be temporarily exempt from participation. In the case of extenuating circumstances preventing an individual from participating in the program, the circumstances shall be presented to the Council on Medical Education.

Residents, interns and other physicians in full-time training will be exempt. The Council on Medical Education will make recommendations to the Board of Trustees on these special cases and will refer to the Board any member failing to comply with the requirements. The Board will have final authority in such matters after due consideration of the individual case.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee received this report which consisted of a detailed plan for implementing a mandatory CME requirement for MSMA membership pursuant to the House of Delegates' directive at the 108th Annual Session.

Mandatory CME requirements are undeniably a thing of the immediate future, be they a requirement for relicensure or for association membership. Your committee would also like to point out that within two years CME requirements will likely be mandatory for medical staff membership in JCAH approved hospitals. Granted the unmistakable fact that mandatory CME is upon us, the only question remaining is who should mandate it? Your committee believes that a CME program operated by the association would be much more palatable than any potential requirement imposed by state law as a condition of continued licensure. Realizing that a CME program run under the aegis of the association would likely mitigate or forestall any attempt to implement CME requirements as a condition of licensure, your committee concurs with the plan developed by the council. Pursuant thereto, your reference committee urges the Council on Medical Education to take a leadership role in developing appropriate CME programs on a local, regional or state-wide level that would enable the membership to meet the requirements of this plan.

In discussion, Dr. Carl G. Evers of Jackson moved that some aspects of this proposal need more study and that this study and recommendation be delayed for one year. The motion, seconded by Dr. Lawrence W. Long, was passed.

The report of the reference committee was adopted as amended.

Report of the Board of Trustees

Organization and Duties. The Board of Trustees is the executive and governing body of the association during vacation of the House of Delegates. It is additionally charged with duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties the Board shall have conducted four meetings during the 1976-77 association year and met daily during the May 2-5, 1977, annual session as required by the association's by-laws. Eight general officers of the association sit with the Board of Trustees at all meetings. They are the president, president-elect, immediate past president, secretary-treasurer, speaker, vice-speaker and two

AMA delegates. The president and immediate past president are voting members of the Board.

This annual report of the Board includes action on matters referred to the Board by the House of Delegates, items relating to management of the association, and activities of the Board's committees during the 1976-77 association year.

Referrals from the House of Delegates. Matters referred to the Board at the 108th Annual Session, 1976, and actions by the House requiring further consideration and implementation include:

1. *Amendments to the MSMA Constitution and By-Laws.* Amendments to the MSMA Constitution and By-Laws were adopted at the 108th Annual Session providing for the establishment of Sections on Psychiatry, Dermatology, and Pathology as part of the annual scientific program. These sections have been organized as part of the Council on Scientific Assembly and all will meet during the 109th Annual Session.

2. *Resolution No. 3.* Resolution No. 3 as adopted by the House of Delegates at the 108th Annual Session provided for reactivation of the Committee on Blood and Blood Banking. This committee has been formed as a committee of The Council on Medical Service and its activities are reported in the council's annual report to the House of Delegates.

3. *Resolution No. 7.* Resolution No. 7 as adopted by the House of Delegates at the 108th Annual Session officially protested the manner of organization and conduct of the Mississippi Health Systems Agency, Inc. as formed under requirements of Public Law 93-641, The National Health Planning and Resources Development Act. The intent of Resolution No. 7 was formally conveyed to the Department of Health, Education and Welfare. Subsequently the president of the Mississippi Health Systems Agency, Inc. resigned and several recommendations and conditions were placed on the agency by the Department of HEW to include: (a) Study and recommendation for redesignating the state into multiple health service areas; (b) Review of physician representatives on the agency by medical societies; (c) Proportionate geographic representation for the Gulf Coast on the sub-area council for that area; and (d) Election of the agency's president by the Board instead of appointment by the Governor.

4. *Resolution No. 8.* Resolution No. 8 as adopted by the House of Delegates at the 108th Annual Session offered the association's support for legislation sought by the University Medical Center. This sup-

port was conveyed to the Vice Chancellor of the Medical Center.

5. *Resolution No. 10.* Resolution No. 10 as adopted by the House of Delegates at the 108th Annual Session called on the AMA to study the costs and benefits of a patient compensation program similar to the present Workmen's Compensation Program. The resolution was subsequently introduced and adopted at the AMA's Annual Meeting and the study is being conducted.

6. *Public Information Campaign Concerning Professional Liability Insurance Crisis.* The House of Delegates at the 108th Annual Session adopted a recommendation by the president that the association mount an extensive public campaign to communicate the professional liability insurance crisis. The campaign was to be financed by a \$15 assessment against each member. A professional advertising agency was retained and the campaign was conducted on TV and through brochures distributed in physicians' offices throughout the state in late December and January. Many favorable comments were received concerning both the content and effect of the public information campaign.

7. *Support for Rural Health.* The House of Delegates at the 108th Annual Session adopted a recommendation from the Council on Medical Service that the association go on record in support of efforts by those concerned in Mississippi which: (a) Give increased attention in the selection process for medical students to applicants from rural areas in recognition of the fact that such students tend to practice in rural areas upon graduation; and (b) Give continued and increased support to family practice and emphasize rural preceptorships and other mechanisms to give medical students an experience with rural practice. This recommendation was subsequently conveyed to the Vice Chancellor of the University Medical Center.

In addition to the above several matters from the 108th Annual Session, the Board wishes to report on the following matters relating to management of the association and activities of its committees:

CHAMPUS. The association became fiscal administrator for professional services under CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) in 1956. Last year the Board reported cutbacks in benefits and reimbursements under CHAMPUS as announced by the Department of Defense for reasons of budget constraint. Of particular concern to the medical profession in Missis-

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Mississippi was the announcement that the program would adopt Medicare reimbursement procedures.

This past year CHAMPUS has implemented even more far reaching changes the most significant of which with respect to its impact on the association called for multiple state and regional administration of CHAMPUS. More specifically in spite of protest by the association and others, Mississippi was combined with Louisiana for purposes of CHAMPUS administration. The logistics, costs and future of serving as a contractor for such a program prohibits the association's involvement. Effective June 1, 1977, the association will cease to serve as fiscal administrator for professional services under CHAMPUS in Mississippi.

Insurance Programs. The Board continues to monitor the professional liability insurance program offered in Mississippi by the St. Paul Companies and the several association-sponsored group insurance programs administered by Thomas Yates and Company of Jackson. During the year a new association group disability plan was implemented and benefits under the present association group life plan were increased 22 per cent without extra cost.

Health Education Articles. During the past year the Board approved preparation and distribution of bi-monthly health education articles to Mississippi newspapers as a public service. The articles are prepared under physician direction and present a brief overview of common medical conditions to include their causes, symptoms and treatment. The articles have been well received and are now carried in some 40 Mississippi newspapers.

Quality of Life Conference. The Board has approved association co-sponsorship of a "Quality of Life Conference" to be conducted in Jackson, May 15-17, 1977. The three-day conference will focus on medical, social, economic and other factors that determine the quality of our children's lives. Other sponsors of the conference are the Junior League of Jackson, The University of Mississippi Medical Center, the National Foundation-March of Dimes, the Mississippi State Board of Health and the Mississippi State Department of Education.

Chiropractic Suit. At the 1975 annual session the House of Delegates approved initiation of necessary legal action to terminate apparent practices of chiropractors in the state which violated provisions of the chiropractic licensing act and resulted in the practice of medicine without a license to the detriment of the public's health. The Board wishes to report

successful conclusion of a suit in this regard in a Hinds County Chancery Court during this past association year.

Malpractice Claim Screening Panel. During the past association year the Board has studied and approved procedures to establish a malpractice claim screening panel. The panel is only established to review a claim based on the request of all involved parties. It is voluntary and its decision is not binding on any party.

Mississippi Foundation for Medical Care. The association has continued its close liaison with activities of the MFMC. The association serves under contract as the data processor for the MFMC. The MFMC will hold its annual membership meeting during the 109th Annual Session.

Mississippi Medical Political Action Committee. MPAC continues to receive growing support from the membership. The MPAC Board is appointed by the association's Board of Trustees. MPAC anticipates increased political education activities and increased involvement in legislative candidate support activities.

Driver Limitation Committee. The driver limitation committee appointed by the Board continues to serve as a medical advisory committee to the Mississippi Department of Public Safety. Members of the committee serve on an individual basis as medical consultants to the Driver Licensing Bureau of the Department.

Committee on Peer Review. This committee has functioned during the past year as a constitutional committee of the association appointed by the Board to conduct peer review activities involving the membership. The committee coordinates its functions with comparable committees of several of the association's component societies.

Committee on Publications. This committee consists of the Editor, the two Associate Editors, and three other members appointed by the Board. The committee is responsible for the ongoing management of the JOURNAL MSMA and annually reports to the Board in this regard. The JOURNAL concluded its 17th consecutive year of operation in 1976 with publication of the 104th issue in December. We are happy to note that the JOURNAL received two awards last year from the Mississippi Press Women and the Mississippi Editors and Directors of Information Association.

Efforts are being made to continually improve the quality of our JOURNAL which a survey revealed last year that some 75 per cent of the membership regu-

larly reads. Among changes planned by the committee for 1977 are a change in cover design and heading typeface. The basic size of the JOURNAL remains at 48 pages. The committee and staff are striving for a greater percentage of advertising pages per issue and the August issue will again contain only the proceedings of the annual session and the constitution and by-laws.

Other matters of interest conducted by the Board during the 1976-77 association year will be the subjects of special reports to the House of Delegates. The Board wishes to express its appreciation to the membership and to the House of Delegates for the support and confidence reposed in the Board during this past association year. Without such support and confidence the Board's job would be impossible. Serving as officers and members of your Board of Trustees this past year were: Drs. Robert S. Caldwell, Tupelo, chairman; Arthur A. Derrick, Durant, vice chairman; Gerald P. Gable, Hattiesburg, secretary; Whitman B. Johnson, Jr., Clarksdale; John R. Lovelace, Batesville; Carl G. Evers, Jackson; Max L. Pharr, Jackson; Joe S. Covington, Meridian; Sidney O. Graves, Natchez; Paul H. Moore, Pascagoula; Lyne S. Gamble, Greenville, president; and Jack A. Atkinson, Brookhaven, immediate past president.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee considered the report of the Board of Trustees and we want to especially call the House's attention to the fact that in June our association will discontinue serving as the fiscal administrator for the professional services portion of the CHAMPUS program. In view of this fact, your reference committee extends a special thanks to the various members of our association who have served on CHAMPUS review committees since 1956.

The report of the reference committee was adopted.

Supplemental Report A of the Board of Trustees

Legislative Activities Background. The 148th Session of the Mississippi Legislature convened in Jackson on Jan. 4, 1977, for its second regular 90 day session of the 1976-1979 legislative term. The Council on Legislation held three meetings during this legislative session and reported to the Board of Trustees at its December and March meetings in this regard. In accordance with prior directives of the House of Delegates, the council directed weekly publication of the Mississippi Medical Legislative

Report and again operated an Emergency Medical Care Unit at the Capitol. The council also directed that beginning this year the "Blue Sheet" should be mailed to the medical auxiliary and the legislators during the Legislative Session.

1977 MSMA Legislative Program. In addition to monitoring all health related bills which were introduced during the 1977 Legislative Session the association had a five-point legislative program to deal with the professional liability problem. These five proposals all of which were based on positions previously adopted by the House of Delegates at the 107th and 108th Annual Sessions and the October 1975 Special Session, were: (1) provide for disciplinary action against any physician who exhibits professional incompetency in the practice of medicine and require hospital medical staffs to report disciplinary action against staff members to the Board of Health; (2) provide legal protection for actions and members of peer review committees and individuals or organizations who provide information to these committees; (3) require that any malpractice claim be reviewed by a panel of one attorney and three physicians before suit could be filed; (4) permit a physician and patient or hospital and patient to enter into a contract whereby both parties agree to arbitrate any dispute that may arise out of the course of their care and treatment; and (5) grant statutory authority for physicians to organize their own nonprofit professional liability insurance organization. A summary of the status of these proposals is discussed below:

1. *Provide for disciplinary action on grounds of professional incompetency.* This proposal was adopted by both the House and Senate and signed into law by the Governor.

2. *Provide legal protection for actions and members of peer review committees.* This was the fifth consecutive year this proposal had been introduced by MSMA, and it was finally passed by both the House and Senate and signed into law by the Governor.

3. *Require that all malpractice claims be reviewed by a panel of one attorney and three physicians before suit could be filed.* This proposal was introduced in the House and assigned to the Judiciary A Committee. The committee reported the bill favorably to the full House but it died on the calendar due to the fact that it could not be acted on prior to the deadline for floor action on bills in the house of origin. This bill would have passed the House in all probability had it not

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been caught by the deadline, although it would have undoubtedly faced rougher going in the Senate. Your board and council feel that this is a beneficial and worthwhile proposal and recommends that it be introduced again in the 1978 Legislative Session.

4. *Provide for contracts between physician and patient to arbitrate future disputes.* This proposal was introduced in the House and also assigned to the Judiciary A Committee. The bill was not reported out of committee due to the fact that extensive research revealed that adoption of the law would conflict with our state constitutional provision which guarantees every citizen the right to take a matter to court if he so chooses. One cannot contract away that right, although it should be pointed out that our existing state law provides that two parties may mutually agree to arbitrate any dispute that arises between them in lieu of petitioning the court to resolve the matter. In view of the constitutional problems inherent in this proposal and the fact that current law permits the resolution of past disputes by arbitration if the parties so choose, it is recommended that this bill not be introduced in future legislative sessions.

5. *Authorize physicians to form their own non-profit professional liability insurance organization.* This bill was introduced in the House, adopted by both the House and Senate and signed into law by the Governor. It should be noted that this proposal had to overcome numerous hurdles throughout the legislative process and would surely have died were it not for the efforts of several physicians and numerous key legislators who believe that such a self-insurance organization will solve many of the existing cost and availability problems.

Other Legislative Activities. In addition to the five-point legislative program noted above, your council, working with the MSMA membership and the Medical Auxiliary, was successful in opposing bills to require mandatory health insurance and Medicaid coverage of chiropractors, authorize a chiropractor to serve on the Board of Health, require the labeling of human blood, legitimize the use of Lactril for cancer patients and authorize optometrists to diagnose and utilize drugs for diagnostic and treatment purposes.

During this session the council and board were made increasingly aware of the fact that physicians

were being severely criticized by members of the legislature and general public for being impervious to problems associated with the cost of health care, particularly as it relates to drugs. This criticism manifested itself this year over a bill which authorized the substitution of generic equivalents by pharmacists for brand name prescriptions. Because of this, it was decided that no drug substitution bill need be opposed which embodies the following principles:

1. ultimate control over the product dispensed is retained by the physician;
2. the patient, not the pharmacist, has the choice of whether he wants the generic product as opposed to the trade brand if the physician authorizes substitution;
3. any cost saving difference between the generic and trade name product is passed on to the consumer; and
4. the physician is statutorily excluded from liability for an adverse drug reaction if the pharmacist selects the product.

The drug substitution bill which was introduced in this session of the legislature contained these four principles; therefore, it was not opposed.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

This report summarizes the status of health legislation considered by the 1977 Regular Session of the Mississippi Legislature and we take particular note of the fact that additional measures authorized by the House of Delegates to deal with the professional liability crisis became law this year. We commend the work of our Council on Legislation as well as the many association members who made personal contact with their legislators on behalf of our legislative program.

This report recommends that we continue to seek the passage of legislation to require that all malpractice claims be reviewed by a panel of one attorney and three physicians before suit could be filed. We concur therein and recommend the adoption of this recommendation.

The report of the reference committee was adopted.

Supplemental Report B of the Board of Trustees

Background. Annually the Board of Trustees and Council on Budget and Finance, along with the association's auditors, examine the financial condition of the association and prepare a budget. Based

on the 1976 audit and projection of our 1977 budget it is the strong recommendation of the Board and Council that there be a dues increase effective with 1978 dues. This recommendation is based on a number of factors among which are: (1) Inflation which through this year will have resulted in a 28 per cent increase in costs of doing business since the last dues increase which was 25 per cent of current dues; (2) The cost of current and future activities of the association which cannot be funded with present dues; and (3) The loss of income to the association resulting from our ceasing to be a fiscal intermediary for the CHAMPUS program effective June 1, 1977.

At the end of 1976 the association had a ratio of current assets to current liabilities of 1.26 to 1. Current assets are cash plus items expected to be converted into cash or used in operations within 12 months. Current liabilities are liabilities due and payable within 12 months. However, with prepaid income (MSMA dues) and funds we are holding for other organizations (AMA dues, etc.) eliminated, our current ratio would be a very weak .56 to 1 with a deficit working capital of \$37,731.90. For the association to be on a sound financial basis the current ratio should be at least 1.50 to 1 with the aforementioned items eliminated.

Your Board and council feel that the association should be run on a sound financial basis. In addition to this need, which is paramount as far as the recommended dues increase is concerned, the Board and council would also note that the association has current and future legal expenses as a result of Governor Finch's activities with respect to the Mississippi State Board of Health.

Finally, we would note that the association presently ranks among the bottom 10 states in amount of membership dues. Most of the other states have larger physician populations to draw on. Two southern medical associations which are comparable in size to ours, Arkansas and South Carolina, have recently raised their dues to \$225 and \$200 respectively.

Recommendation: The Board of Trustees and Council on Budget and Finance recommend a \$75 dues increase effective with 1978 dues.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee considered this report from the Board of Trustees and Council on Budget and Finance which recommends an increase in our 1978 dues from \$125 to \$200.

No one spoke in opposition to this recommendation at the committee's hearing and we all recognize that maintaining a strong, effective and viable medical association requires not only a sacrifice in the individual member's time, but adequate financial support as well. If your association is to continue to fight for the principles in which we believe then our fiscal policies must be adequate to support that level of activity. Your committee wants to especially point out that this increase will make our dues level commensurate with those in other states of comparable size and physician population. Therefore, we concur with the recommendation of the Board and council.

The report of the reference committee was adopted.

Supplemental Report C of the Board of Trustees

Background. In Supplemental Report E to the House of Delegates at the 107th Annual Session, May 1975, the Board of Trustees and Special Committee on Professional Liability Insurance reported a *worsening professional liability insurance* market in Mississippi. Whereas, there had recently been several companies writing this coverage in the state there was then one. More particularly, that one carrier had announced implementation of a "claims made" policy "as an alternative to completely withdrawing from the market" and the carrier's rates for excess limits coverage had *increased by 200 per cent*. A claims made policy only covers claims reported during the policy period as opposed to the traditional "occurrence type" policy which covers any claim incurred during the policy period no matter when reported. Under the "claims made" policy coverage of claims reported after retirement, death or change to another professional liability program, if one is available, is handled by the purchase of an "endorsement" which is *priced at the time of purchase*.

In recognition of these factors the Board announced plans to study alternatives to the professional liability insurance market. The Board's report in this regard was presented to a special session of the House of Delegates in October 1975.

In that report the Board recognized the successful experience of insurance companies writing physicians' professional liability coverage in Mississippi and noted that the state had apparently become the victim of these carriers' reaction to their national experience. The Board also reported the growing trend toward establishment of "captive" professional liability coverage programs by state medical associations and noted plans of the American Medical Association to establish a reinsurance program for such

HOUSE OF DELEGATES / Continued

captive programs. The Board then described its investigation of a nonprofit, physician membership corporation to provide occurrence type professional liability coverage and recommended:

- a. That the nonprofit physician membership corporation be chartered under the laws of Mississippi;
- b. That contributions to the corporation be tax exempt to the same extent as present liability;
- c. That reinsurance of the corporation's risk and excess limits coverage be available;
- d. That a minimum of 750 physicians express their intent to become members of the corporation through investment of an initial membership fee to provide a pool of approximately \$700,000.

The above recommendations were approved by the House after the House noted that if a minimum of 750 physicians joined the proposed corporation they represented a majority of MSMA members and thus a majority vote for the proposal.

At the May 1976 meeting of the House of Delegates the Board reported incorporation of the Mississippi Medical Fraternal and Educational Society and formation of the American Medical Assurance Corporation by the American Medical Association as a reinsurance facility for "captive" companies sponsored by state medical associations.

Current Status of Association Sponsored Captive Program. During the past year the association has proceeded to organize the Mississippi Medical Fraternal and Educational Society and at this time a solicitation for membership and funding is in process. This will run through mid-June, 1977. The Board feels it is worthy to note a number of particular events that have occurred with respect to organization of the society and the professional liability insurance market in Mississippi:

- a. Over 800 MSMA members expressed an interest in formation of the society through a mail solicitation;
- b. At this time there is still only one company in the state writing new business for professional liability and that company's premiums have increased some 140 per cent in the last two years. Additionally, the company is now projecting a 400 per cent increase in premiums over the first five years of its claims made policy;
- c. As noted previously, future premiums for the "reporting endorsement" for the claims made policies now carried by most Mississippi physi-

cians cannot be accurately predicted. An example of its current cost is illustrated by the case of an obstetrician who retired in December 1975 and was quoted a premium of some \$4,700. This did not include the additional premium of some \$1,300 payable by the professional association of which the physician was a member. This was after the physician had been on a claims made policy for only one year. A modest projection of what his premium would amount to after four to five years on the claims made policy would equal two to three times the \$4,700 premium he was quoted in 1975.

d. The association has successfully sponsored legislation giving statutory recognition to the Mississippi Medical Fraternal and Educational Society.

e. Over the past few years only some 25 per cent of premiums collected by carriers in Mississippi for basic \$100,000/300,000 coverage have been paid for claims. Remaining premiums have gone for expenses and for claims reported but not paid or for claims incurred but not reported. No premiums collected for \$1 million/3 million excess coverage have gone to pay any claims in Mississippi. Such premiums now amount to 100 per cent of basic coverage premiums.

f. Some 18-25 per cent of premiums collected for professional liability coverage of Mississippi physicians have gone for commissions, admitted profit and insurance taxes. None of these will be expenses in the operation of the Mississippi Medical Fraternal and Educational Society.

g. Members of the Board of the Mississippi Medical Fraternal and Educational Society have had initial discussions with officials of a nationally recognized insurance and actuarial consulting firm, concerning the proposed operation of the Mississippi Medical Fraternal and Educational Society. If the society becomes operational it is planned to employ a consulting firm to advise on both the staffing and operation of the society.

Members of the Board of Trustees and Board of the Mississippi Medical Fraternal and Educational Society will be available to answer questions concerning the society at the 109th Annual Session. Dr. Faser Triplett of Jackson currently serves as president of the society.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee received this report

MEETINGS

National and Regional

American Medical Association, House of Delegates Interim Mtg., Chicago, Dec. 4-7, 1977; Winter Scientific Mtg., Miami Beach, Dec. 10-13, 1977. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

Cancer Concepts 1977, Oct. 16-18, 1977, Sheraton Inn, Gatlinburg, TN. For information contact: Dr. Harvey Goodman, Department of Continuing Medical Education, University of Tennessee Center for the Health Sciences, 1924 Alcoa Highway, Knoxville, TN 37920.

Third Annual Symposium on Arthritis and Musculoskeletal Diseases, Aug. 25-27, 1977, Grand Hotel, Point Clear, AL. Sponsored by Mississippi and South Alabama chapters of the Arthritis Foundation.

State and Local

Mississippi Academy of Family Physicians, Annual Meeting, July 12-15, 1978, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 110th Annual Session, May 1-4, 1978, Jackson. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Henry McCrory, Secy., P.O. Box 340, Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. G. L. Arrington, Jr., Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1167, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Charles A. Osborn, Secy., 207 Meadow Lane, Eupora 39744. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. George Walker, Secy., 102 W. Lampkin St., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Clyde Gunn, Jr., Secy., P.O. Drawer G, Moss Point 39563. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Thomas Blake, Secy., 424 S. 13th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.



When choosing a diuretic for day-in-day-out hypertension control with comfortable compliance...

The agent you choose in mild to moderate essential hypertension should offer (1) long-term effectiveness, (2) patient comfort and compliance.

Zaroxolyn offers both.

In one long-term study¹ Zaroxolyn brought moderately elevated (average 161/109 mm Hg) blood pressure down to the range of normotension—and held it there for a year or more.

The investigator noted, "Patient cooperation was surprisingly good for a study of such duration [2½ years]. The once-daily dosage schedule with

metolazone [Zaroxolyn] no doubt contributed to patient compliance."

Overall compliance with Zaroxolyn is good—very good. An analysis of controlled clinical studies involving 188 Zaroxolyn patients showed that only eight discontinued therapy because of side effects. That's a discontinuation rate of only 4.3%, and broader clinical experience appears to substantiate this low rate²

Zaroxolyn. For long-term control and comfortable compliance in mild to moderate hypertension.

Recommended initial dosage in mild to moderate essential hypertension—2½ to 5 mg once daily

Zaroxolyn[®]
(metolazone, Pennwalt)

2½-mg, 5-mg and 10-mg tablets

once-daily antihypertensive diuretic

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary.

Indications: Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma; allergy or sensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing

age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use.

Precautions: Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather.

Adverse Reactions: Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth,


hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks.

Usual Initial Once-Daily Dosages: mild to moderate essential hypertension—2½ to 5 mg, edema of cardiac failure—5 to 10 mg, edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy.

How Supplied: Tablets, 2½, 5 and 10 mg

References:

1. Dornfeld L, Kane R. Metolazone in essential hypertension. The long-term clinical efficacy of a new diuretic. *Curr Ther Res* 18: 527-533, 1975
2. Data on file. Medical Department, Pennwalt Prescription Products

 **PENNWALT**
Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

Mississippi State Medical Auxiliary Association

It is my pleasure to serve this year as president of the Mississippi State Medical Association Auxiliary. We are an active organization with 1,010 state members, 859 national members and 13 junior affiliate members. We have 25 local auxiliaries and 21 state projects—plus numerous projects on local levels. We take pride in being married to Mississippi physicians, and we want to be working partners with you on behalf of medicine and the health care in our communities.

At our state convention in Biloxi this past May we registered 200 Auxiliary members, presented \$13,452.20 in AMA-ERF funds to the Dean of the Medical School, welcomed our national Auxiliary president, conducted productive business sessions and enjoyed four days of fun and fellowship together.

At our national convention in San Francisco in June, Mississippi was well represented by voting delegates, alternate delegates and attendees. Imogene Brown served as national timekeeper for the convention, and Jean Hill is beginning her second year as Southern Regional AMA-ERF Chairman—coordinating the work in 12 states.

Three of our state members have been invited to participate in national workshops in Chicago in August: AMA-ERF Chairman Margaret Amacker, Membership Chairman Roberta Barnett, and Project Bank Coordinator Pat Warfield. In October, Sue Rowlett, Lucy Hilbun and three county presidents-elect will attend a national workshop in Chicago.

On the state level we are currently trying:

To increase our membership to 1,051 national members.

To augment and permanently house our museum collection of old medical instruments.

To enlarge the effectiveness of *Distaff*, our state publication.

To fund two Nurses Loan Scholarships.

To fill emergency Hygiene Kits for overseas disaster areas.

To publicize better legislation, health education, mental health and community service.

To encourage active involvement in all projects endorsed by the Mississippi State Medical Association.

If your spouse is not a member of Mississippi State Medical Association Auxiliary, please encourage her or him to join. It's good for them. It's good for you. "It's good medicine—at a good price." National dues are \$7.00; state dues are \$5.00.

Let us know when we can be of help to you.

MRS. WILLIAM M. HILBUN, JR.
President, MSMA Auxiliary



dealing with the organization and status of the Mississippi Medical Fraternal and Educational Society as authorized by the October 1975 Special Session of the House of Delegates. Your committee wishes to point out that this society was organized to provide professional liability coverage to its members if the requisite number (750) of physicians exhibit their interest therein by contributing the \$1,000 membership fee. The society evolved out of an attempt by this House of Delegates to provide a sound alternative to the existing commercial professional liability insurance market and as a service to our membership if we elect to utilize that alternative. The society is currently engaged in membership solicitation for a period of 90 days. The success or failure of this membership solicitation will determine whether or not we as physicians are satisfied with the existing liability insurance market or whether we want to truly control our own destiny in the future. Commensurate thereto, we note that the officers and board of the society as well as our own MSMA staff are available to meet with any component society or hospital staff to discuss the fraternal society's plans and program.

The report of the reference committee was adopted.

Supplemental Report D of the Board of Trustees

Background. The Board of Trustees has considered methods of providing more meaningful participation in the activities of the association by interns and residents in Mississippi. At this time the American Medical Association has established a "Resident Physician Section" in conjunction with its annual and clinical meetings and numerous state medical associations have acted to establish formal mechanisms for interns and residents to participate in their activities.

Recommendation. After consideration of mechanisms that might be formalized to provide greater participation in the activities of our association by the some 250 interns and residents in the state it is the Board's recommendation that an interns and residents business section be organized as a formal section of the association's annual session. The section should be financially supported by the association to the same extent as the other MSMA sections and staff support should be provided by MSMA staff. The section should elect its own chairman and secretary who would by reason of their office serve as voting members of the House of Delegates. The section should be encouraged to present programs of medical socioeconomic interest and serve as an

annual forum in this important area for not only the practicing medical profession of tomorrow, but also for our present members.

Adoption of this recommendation will result in amending Chapter IV, MSMA By-Laws to provide for an interns and residents business section as one of the sections of the association.

Resolution No. 8, Interns and Residents Participation in MSMA

Dr. Louis C. Lehmann:

WHEREAS, The Homochitto Valley Medical Society recognizes the need for more meaningful participation in the Mississippi State Medical Association by the interns and residents in Mississippi; and

WHEREAS, Numerous states have established formal mechanisms for interns and residents to participate in their activities; and

WHEREAS, In consideration of various mechanisms to include residents and interns in the association, it was noted that interns are required to choose a specialty: Surgery, medicine, family practice, etc.; now therefore be it

Resolved, That interns and residents be invited to join the MSMA section of their choice; and

Be It Further Resolved, That as members they be encouraged to vote and become officers, and assist in arranging programs; and

Be It Further Resolved, That through active participation in the various sections and the medical association, the interns and residents will become an active part of the practicing medical profession at an earlier age.

Report of the Council on Constitution and By-Laws

Your reference committee considered these two referrals together since they both address the same subject, namely participation in the activities of the association by interns and residents.

Report D of the Board of Trustees recommends the establishment of an interns and residents business section as one of the sections of the association. Resolution No. 8 introduced on behalf of the Homochitto Valley Medical Society "Resolved, that the interns and residents be invited to join the MSMA scientific section of their choice."

Your reference committee believes that both these referrals address a goal on which we all agree, namely, the desirability of meaningful participation in this association by the interns and residents in our state. The only question really before us is how best to accomplish this.

HOUSE OF DELEGATES / Continued

Your reference committee had the benefit of discussion on this matter from Dr. Hugh Gamble, president of the House Staff Association. It is Dr. Gamble's view and ours that mechanisms already exist for participation in the annual scientific program of the association by interns and residents. They receive an invitation to attend without a registration fee and participate in our annual meeting.

We and Dr. Gamble believe that the greatest need for more meaningful participation in the association by interns and residents lies in the area of communicating association policy and programs. We therefore recommend that Report D of the Board of Trustees and Resolution No. 8 be not adopted and in lieu thereof we recommend that the association's Constitution and By-Laws be amended to provide for selection of two delegates to the House of Delegates by the House Staff Association of the University Medical Center. We further recommend that a mechanism be established for complimentary distribution of the *MSMA Blue Sheet* and *JOURNAL MSMA* to interns and residents at the University Medical Center.

Your reference committee's recommendation concerning selection of delegates to the House of Delegates, if adopted, will be an amendment to Article VIII of the MSMA Constitution and as such must lie on the table until the next annual session.

In discussion, Dr. Myron W. Lockey of Jackson, associate editor of the *JOURNAL MSMA*, explained that complimentary copies of the *JOURNAL MSMA* would cost approximately \$4,000 per year and moved that one or two copies of the *JOURNAL* be sent to each department library at the University Medical Center instead of to all interns and residents at UMC. The amendment was seconded by Dr. W. Moncure Dabney of Crystal Springs and passed.

The report of the reference committee was adopted as amended.

Supplemental Report E of the Board of Trustees

In May of 1976, Governor Finch appointed two physicians to the State Board of Health which were in conflict with Section 41-3-1 of the Mississippi Code. This statute requires that the Governor's Board appointees be selected from the list of nominees submitted by MSMA.

In June 1976, the Governor was advised that these two appointments did not meet the requirements of Section 41-3-1 and nominations made by the House of Delegates for Board of Health vacan-

cies were again submitted to the Governor. Shortly thereafter a letter was received from the Governor stating that he was aware of the law and requesting a new list of nominees that would include the names of the two physicians previously appointed by the Governor. The Governor was then advised that the Board of Trustees would consider this request at its regular August meeting.

At its August meeting a representative of the Governor met with the Board to discuss this matter and it was thought that an agreeable solution had been reached which satisfied the Governor, yet did not do violence to the law or the integrity of the nominations made by the House of Delegates. A three man committee was also appointed by the chairman of the Board of Trustees at the Governor's request to work with him as a liaison on this and other matters that might arise in the future. The following month, however, the solution supposedly reached at the August Board meeting was ignored and both of the illegal appointees attended their first Board of Health meeting. Additionally, the liaison committee which was appointed at the Governor's request has never been contacted or utilized.

In October the Board of Trustees held a special called meeting to again consider this matter. Prior to this meeting certain members of the Board and the MSMA staff were asked to meet with representatives of the Governor to discuss the Board of Health matter. The meeting was held with the Governor's legal advisor and one other individual and was to the effect that the Governor intended that the two physicians who were appointed illegally serve on the Board of Health, that such a law restricting his appointments was illegal and that if MSMA did not nominate the two physicians the Mississippi Medical and Surgical Association would nominate them and as far as the Governor was concerned that met the requirements of the law.

Immediately following this meeting with the Governor's representatives the Board of Trustees voted to request the Attorney General to institute necessary legal proceedings to remove the two illegal appointees from the Board of Health or give the association permission to initiate such proceedings.

At its regular December meeting the Board of Trustees again considered the Board of Health matter and authorized the employment of legal counsel to initiate legal action if and when the Attorney General decided to grant permission to bring the necessary proceedings.

In January, the Governor again submitted the

names of the two illegal appointees to the Senate for confirmation and the chairman of the committee in which the confirmations were pending was advised by the MSMA President that both appointments were in conflict with existing state law.

In February the Governor appointed another physician to the Board of Health to fill the unexpired term of Dr. Joe McKinnon, and he, too, had not been nominated by MSMA. In submitting the appointment to the Senate, however, the Governor stated that all three of his contested appointments had been made from a list of nominees submitted by the Mississippi Medical and Surgical Association.

In March, the Senate Public Health Committee held a hearing on the Governor's Board of Health appointees at which the Attorney General stated that appointees which had not been selected from a list of MSMA nominees were illegal. At the conclusion of the meeting a representative of the Governor's office and the Mississippi Medical and Surgical Association sought and accepted an invitation to meet with the Board of Trustees at its regular March meeting the following week to see if a resolution of the problem could be reached. The next day, however, a representative of the Governor's office advised Dr. Gamble that unless all the Governor's appointees were nominated by MSMA a lawsuit would be filed within the week. The following Friday a lawsuit was brought in Federal Court against MSMA. Plaintiffs in the suit are Gov. Finch, Dr. Howard Clark, Dr. Bill Middleton, Dr. Gilbert Mason, Dr. A. B. Britton, Dr. George W. Howell and Ms. Juanita Ginn. The suit alleges that MSMA has discriminated against blacks and women by never having nominated either to the Board of Health, that MSMA "controls" the Board of Health, that consumers are denied the right to serve on the Board of Health and that the law which requires Board of Health appointees to be selected from MSMA nominees is an unconstitutional infringement of the Governor's executive powers.

At its March meeting the Board of Trustees authorized legal counsel to initiate a quo warranto proceeding to remove any illegal appointees to the State Board of Health.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee considered this report of the Board dealing with matters surrounding the appointments to the State Board of Health. In this regard, we were especially privileged to have Mr. James K. Child, Attorney at Law, appear before the

committee to discuss the lawsuit which has been filed against the association as a result of having contested the Governor's illegal appointments to the Board. Your committee especially wants to note that in this lawsuit the Governor and three members of this association, two of whom are delegates to this meeting have accused our association of having "exercised a practice of racial exclusivity," of having "entered a practice of sex exclusivity," and of having "discriminated against all members of the black race who are physicians." Despite the Governor's and our own members' allegations, this subterfuge will not hide the fact that the Governor interjected race into this issue 10 months after he had failed to pressure the association into nominating the two white physicians he wanted to appoint to the Board. This kind of political "horsetrading" has no place in an agency of such importance as the Board of Health. The law which provides for Board of Health appointments to come from nominees elected through the democratic process of this House was designed to prevent just such political manipulation. We urge that our Board of Trustees and officers, through the support of this House and our entire membership, continue to take whatever actions are necessary to assure that mandates of the law dealing with Board of Health appointments are obeyed.

The report of the reference committee was adopted.

Supplemental Report F of the Board of Trustees

Scheduling of MSMA Annual Sessions. Section 2, Article V of the MSMA Constitution states that "... the time and place for holding the annual session shall be fixed by the House of Delegates . . ." and Section 1, Chapter 11 of the By-Laws states that "... the session . . . shall be held prior to the annual session of the American Medical Association. . . ."

Because of scheduling difficulties, the House of Delegates approved a four year advance schedule in 1967. Additionally, in 1970 the House of Delegates directed that future annual sessions be scheduled to avoid conflicts with Mother's Day and with municipal elections. The former occurs on the second Sunday in May; primaries for the latter occur on the second Tuesday in May every four years.

Dates and Sites for the Annual Session. At the 106th Annual Session in 1974 the House of Delegates directed that the association meet in Jackson in 1976 and thereafter meet on the Gulf Coast in odd numbered years. Based on this and other requirements as noted above, the present schedule of MSMA Annual Sessions is as follows:

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<i>Annual Session</i>	<i>Place and Date</i>
110th	Jackson, May 1- 4, 1978
111th	Biloxi, May 7-10, 1979
112th	Jackson, May 5- 8, 1980

Scheduling of 113th Annual Session. Based on the MSMA Constitution and By-Laws and past policies of the House of Delegates the 113th Annual Session should be conducted May 4-7, 1981, in Biloxi.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee received the report of the Board of Trustees concerning scheduling of annual meetings of the association. The present annual session schedule as previously approved by the House of Delegates is as follows:

<i>Annual Session</i>	<i>Place and Date</i>
110th	Jackson, May 1- 4, 1978
111th	Biloxi, May 7-10, 1979
112th	Jackson, May 5- 8, 1980

The Board, following requirements of the MSMA Constitution and By-Laws concerning scheduling of annual sessions and policies of the House of Delegates in this regard, recommends that the 113th Annual Session be conducted at Biloxi, May 4-7, 1981. We concur in this recommendation.

The report of the reference committee was adopted.

Report of the Secretary-Treasurer

Dr. J. Elmer Nix: Duties and Responsibilities. As an elected general officer of the association, your Secretary-Treasurer is charged with such duties as ordinarily devolve upon the secretary of a corporation by law, custom, and usage. Additionally, he is the constitutional designee to serve as chairman of the Council on Scientific Assembly and member *ex officio* of all councils and committees.

Membership. Total membership as of Dec. 31, 1976, was as follows:

- 1,447 Paid Active Members
- 102 Exempt Members

This is a total of 1,549 MSMA for 1976. As of April 1, 1977, our current year's membership was:

- 1,391 Paid Active Members
- 112 Exempt Members

This is a total of 1,503 for 1977, as of April. Additional payments of dues have been made since preparation of these data.

Fiscal Reporting. In accordance with usual prac-

tice, your Secretary-Treasurer submits a condensed statement of your association's financial condition. The Council on Budget and Finance prepared the budget for 1977 which was approved by the Board of Trustees in accordance with association policy.

MISSISSIPPI STATE MEDICAL ASSOCIATION Condensed Statement of Financial Condition Dec. 31, 1976

ASSETS	
<i>Current Assets</i>	
General Fund	
Cash on Deposit	\$291,582.68
Accounts Receivable—	
JOURNAL	2,762.74
Accounts Receivable—	
CHAMPUS	15,150.00
Other Current Receivables	37,481.64
Inventory—Insurance Forms	885.00
Prepaid Expenses	2,721.69
Total Current Assets	\$350,583.75
<i>Fixed Assets</i>	
Building, Computer, Office	
Furniture and Equipment,	
Less Depreciation	\$242,770.84
Land (at cost)	14,242.38
Total Fixed Assets	\$257,013.22
<i>Deferred Expenses</i>	
Deferred CHAMPUS Expenses	\$ 6,920.14
Deferred Public Relations	
Expense	4,357.33
Total Deferred Expenses	\$ 11,277.47
<i>Other Assets</i>	
Refundable Deposits	\$ 25.00
	\$ 25.00
Total Assets	\$618,899.44

LIABILITIES AND NET WORTH

<i>Current Liabilities</i>	
Accrued Expenses	\$ 33,963.02
Accounts Payable	
Local Society Dues	7,007.00
Auxiliary Dues	1,748.00
AMA dues & ERF	179,540.00
AMPAC & MPAC	3,500.00
Government—Emcro	11,126.10
Legal Fund Reserve	1,961.14
Malpractice Fund Reserve	1,000.00
Mortgage Payable	
Current Portion—Note C	7,120.00
Lease Purchase Payable	
Current Portion—Note E	29,017.80
Accrued & Withheld Taxes	1,718.30
Other Current Liabilities	547.09
Total Current Liabilities	\$278,248.45
<i>Long-Term Liabilities</i>	
Mortgage Payable—Deposit	
Guaranty National Bank—	
Note C	\$ 40,940.00
Lease Purchase Payable—	
Note E	29,276.48
	\$ 70,216.48
<i>Deferred Income</i>	\$110,067.20
<i>Net Worth</i>	
Unappropriated Net Worth	
Dec. 31, 1975	\$142,625.17

Net Income for Year Ended	
Dec. 31, 1976	17,742.14
Net Worth, Dec. 31, 1976	\$160,367.31
Total Liabilities and Net Worth	\$618,899.44

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee received the report of our Secretary-Treasurer. We are happy to note that the association continued to increase in membership last year. We recommend that we continue our efforts in this regard.

The report of the reference committee was adopted.

Report of the Executive Secretary

Mr. Charles L. Mathews: The office of the Executive Secretary staffs and administers the activities of the association under the direction and supervision of the Board of Trustees. This report is intended as an overview of your administrative staff and association programs and activities.

Programs and Activities. The association continued and expanded its programs and services during the 1976-77 association year. In new activities staff has been concerned with organization of the malpractice public relations program conducted by the association in late 1976, organization of the Mississippi Medical Fraternal and Educational Society, and legal matters affecting the association and the practice of medicine in Mississippi. On-going staff activities have continued, and hopefully improved, as reflected in the Board, Councils and Committees reports to this annual session of the House of Delegates.

With the association ceasing its operations as a fiscal intermediary for the CHAMPUS program effective June 1, 1977, one of the oldest programs the association has conducted will come to an end. The association became a CHAMPUS fiscal intermediary in 1957. It is anticipated that expanding and new programs will replace the CHAMPUS program and be more meaningful to the general membership.

Staff. There are at present eight executive staff members. Nine positions have been authorized since 1970 and a vacancy for a secretary will be filled during the 1977-78 association year. Present executive staff members are: William F. Roberts, Assistant Executive Secretary and Legal Counsel; H. Cody Harrell, Assistant Executive Secretary and Controller; Nola Gibson, Managing Editor, JOURNAL MSMA; Barbara Shelton, Membership Director; Bobby Pierce, Data Manager and Programmer; Cindy Ammons, Secretary; Beth Hamilton, Secre-

tary to the Executive Secretary; and Charles L. Mathews, Executive Secretary.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee received the report of our executive secretary concerning staff activities. We wish to commend our staff for their continued good work.

The report of the reference committee was adopted.

Resolution No. 1, In Memoriam

Dr. J. Elmer Nix:

WHEREAS, There are absent from among our numbers 22 members who have been called by Divine Providence since the 108th Annual Session; and

WHEREAS, Although we are grieved by the passing of these beloved colleagues and friends, we are inspired by their lives of service and professional attainment; and

WHEREAS, This expression of our grief, deep affection, and respect should be recorded permanently among official records of the Mississippi State Medical Association; now therefore, be it

Resolved, That this House of Delegates does mourn the passing of the following esteemed colleagues:

G. Lacey Biles, Sumner, Aug. 1, 1976
 Julian C. Bramlett, Oxford, Feb. 16, 1977
 George A. Brown, Water Valley, Nov. 30, 1976
 William A. Brown, Jr., Mathiston, July 3, 1976
 Grover C. Denson, Long Beach, April 11, 1976
 Clyde A. Ellis, Clarksdale, June 16, 1976
 Max L. Golden, Laurel, Jan. 23, 1977
 Stanley A. Hackman, Biloxi, Aug. 2, 1976
 James D. Hadley, Bay Springs, June 30, 1976
 Dewitt Hamrick, Corinth, June 19, 1976
 William F. Hand, Jackson, Oct. 31, 1976
 Guy C. Jarratt, Vicksburg, April 17, 1976
 A. C. Kimbriel, Jr., Drew, Aug. 4, 1976
 Nathan B. Lewis, Vicksburg, Nov. 30, 1976
 Wayne A. Lindsey, Booneville, Feb. 20, 1977
 George S. Mason, Yazoo City, May 2, 1976
 James T. McRee, Louin, Dec. 30, 1976
 J. A. Milne, Jackson, Dec. 11, 1976
 Elmer W. Mosley, Biloxi, April 22, 1976
 Thomas S. Robertson, Jackson, Jan. 15, 1977
 Thomas A. Robinson, Whitfield, Aug. 26, 1976
 R. P. Vincent, Hattiesburg, Dec 1, 1976

Action of the House of Delegates

Without objection, Resolution No. 1 was acted

HOUSE OF DELEGATES / Continued

upon without referral and adopted by the House of Delegates with all present standing in silent tribute.

Resolution No. 2, Physicians' Professional Liability Insurance

Dr. Andrew K. Martinolich:

WHEREAS, The increasing cost of physicians' professional liability insurance is a matter of great concern to both the public and the medical profession; and

WHEREAS, Only about 30 per cent of professional liability claims against physicians result in a finding for the plaintiff; and

WHEREAS, The fact that 70 per cent of the claims filed against physicians do not result in payment to the plaintiff would indicate that perhaps suits are being filed without proper legal consideration; and

WHEREAS, The costs of investigating and defending these nonmeritorious claims are still considered a loss by the carrier, which losses must be passed on in the form of higher professional liability premiums; now therefore be it

Resolved, That in the interest of the public and reducing the costs of medical care all members of the Mississippi State Medical Association voluntarily contribute to a legal fund established by the association to seek legal redress against any plaintiff and/or attorney filing a malpractice suit against a member of the association which appears to have no legal foundation and has not been adequately researched.

Be It Further Resolved, That the initial action include a careful, statewide search and a careful study of a suitable single case to be used as the initial suit.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

This resolution was introduced by Dr. Andrew K. Martinolich, delegate from the Coast Counties Medical Society. This resolution provides:

"Resolved, That in the interests of the public and reducing the costs of medical care all members of the Mississippi State Medical Association voluntarily contribute to a legal fund established by the association to seek legal redress against any plaintiff and/or attorney filing a malpractice suit against a member of the association which appears to have no legal foundation and has not been adequately researched.

"Be It Further Resolved, That the initial action include a careful, statewide search and a careful single case to be used as the initial suit."

Your reference committee heard considerable discussion on this resolution, nearly all of which was in support of its passage. The committee feels that such an activity should only be conducted after careful study. Your reference committee therefore recommends adoption of the following substitute resolution:

"Resolved, That the Board of Trustees and MSMA legal counsel review any request for financial assistance from any MSMA member who intends to file a countersuit against any patient and/or lawyer and if a decision is made to render such assistance that it be only in the amount of such voluntary contributions which may be made by the MSMA membership upon notice that such countersuit will be filed."

After much discussion pro and con, this report of the reference committee was adopted as written.

Resolution No. 3, MSMA Support for Blue Cross-Blue Shield of Mississippi, Inc.

Dr. Ellis M. Moffitt:

WHEREAS, As Blue Cross-Blue Shield of Mississippi, Inc., has served as a Blue Shield plan from its beginning almost 30 years ago; and

WHEREAS, Since 1968 Blue Cross-Blue Shield of Mississippi, Inc., has operated as a Blue Shield plan on conditional approval from National Association of Blue Shield plans because of the withdrawal of endorsement and sponsorship of the Plan by Mississippi State Medical Association; and

WHEREAS, Blue Cross-Blue Shield of Mississippi, Inc., has made concentrated and special efforts to improve its Blue Shield operations in general and particularly as to points of dissatisfaction expressed by Mississippi State Medical Association; and

WHEREAS, Improvements have been made in the Plan's Blue Shield operations and the Plan is now carrying on an expanded and more comprehensive Blue Shield program than ever before; and

WHEREAS, Cooperation and understanding between Mississippi State Medical Association and Blue Cross-Blue Shield of Mississippi, Inc. have grown with the undertaking of projects of common interest and as a result of efforts at closer communication; now therefore be it

Resolved, That the Mississippi State Medical Association express its support for Blue Cross-Blue Shield of Mississippi, Inc., as a Blue Shield plan; and

Be It Further Resolved, That Mississippi State Medical Association notify National Association of Blue Shield Plans that Blue Cross-Blue Shield of Mississippi, Inc., has substantial support of the med-

ical profession as evidenced by the approval of Blue Cross-Blue Shield of Mississippi, Inc., by the Mississippi State Medical Association; and

Be It Further Resolved, That Mississippi State Medical Association once again supply nominations for the physician-director posts of Blue Cross-Blue Shield of Mississippi, Inc., at such times as are appropriate prior to the election of such directors.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

Your reference committee considered Resolution No. 3 introduced by Dr. Ellis Moffitt, delegate from Central Medical Society. This resolution states that:

"Resolved, That the MSMA express support for Blue Cross-Blue Shield of Mississippi, Inc. as a Blue Shield Plan."

This resolution elicited the most discussion before the committee and we heard varying points of view. Realizing that Blue Cross-Blue Shield has just undergone a change in leadership and there is no immediate necessity for the association's endorsement, we recommend the adoption of the following substitute resolution:

"Resolved, That the Board of Trustees study the endorsement of Blue Cross-Blue Shield of Mississippi, Inc. and recommend to the House of Delegates at the 110th Annual Session whether such endorsement should be reinstated."

The report of the reference committee was adopted.

Resolution No. 4, Establish a Section on Orthopaedic Surgery

Dr. J. Elmer Nix:

WHEREAS, The American Medical Association has for some time recognized a section on orthopaedic surgery within its organization; and

WHEREAS, The Mississippi Orthopaedic Society is a recognized branch of the American Academy of Orthopaedic Surgeons, and all its members are in good standing with the American Academy of Orthopaedic Surgeons; and

WHEREAS, Members of the Mississippi Orthopaedic Society have for some time been very active in affairs of the Mississippi State Medical Association; and

WHEREAS, The Mississippi Orthopaedic Society has previously expressed its desire to develop a scientific section of the Mississippi State Medical Association; now therefore be it

Resolved, That the Mississippi State Medical Association recognize the specialty of orthopaedic sur-

gery as a section within the association under requirements of Chapter IV, MSMA By-Laws.

Report of the Council on Constitution and By-Laws

This resolution was introduced on behalf of the Mississippi Orthopaedic Society and *"Resolved*, that the Mississippi State Medical Association recognize the specialty of orthopedic surgery as a section within the association under requirements of Chapter IV, MSMA By-Laws."

Last year at the 108th Annual Session of the association your reference committee noted that the continued addition of new specialty sections to the annual scientific program of the association created a financial and logistical burden. Three new sections were added at the meeting and the number of scientific sections increased to twelve.

At that time it was the feeling of your reference committee, and it was so stated to the House of Delegates, that the Council on Scientific Assembly should plan a general scientific program for the membership and then if the twelve scientific sections composing the council wanted to hold meetings they should do so in conjunction with their own specialty societies, at their own expense. It was your reference committee's view in this regard that this would solve both the financial and logistical problems of adding new sections. The only condition then to the acceptance of additional specialty sections would be an acknowledged desire on the part of the specialty section to improve the quality of our annual scientific program for the membership.

Your reference committee still believes that this is the proper plan. We also believe that the orthopedic surgeons in our state should be represented on the Council on Scientific Assembly as one of our scientific sections and therefore recommend adoption of Resolution No. 4.

The report of the reference committee was adopted.

Resolution No. 5, Rescinding Restriction of Licensing Procedures for Obtaining Canadian Nurses

Dr. Ellis M. Moffitt:

WHEREAS, There is a shortage of nurses in our state, and

WHEREAS, 90 per cent of the nurses graduating in 1977 in Canada will have no place of employment in that country; and

WHEREAS, 21 states including Arkansas, Alabama, Louisiana and Tennessee now license Ca-

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nadian nurses by "endorsement" of their Canadian license, thereby putting Mississippi at an unfair advantage in recruiting Canadian nurses; and

WHEREAS, Recruiting efforts to bring Canadian nurses to Mississippi can be more successful if the Mississippi Board of Nurses will grant licensure to Canadian licensed nurses by endorsement, as do our sister states, instead of requiring them to take our licensing examination; now therefore be it

Resolved, That the Mississippi State Medical Association go on record as urging the Mississippi Board of Nurses to grant licensure to Canadian nurses by endorsement of their Canadian license to practice nursing.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

This resolution was introduced on behalf of Central Medical Society. The resolution states:

"Resolved, That the Mississippi State Medical Association go on record as urging the Mississippi Board of Nursing to grant licensure to Canadian nurses by endorsement of their Canadian license to practice nursing."

The resolution notes that some 21 states, including many of our neighboring states, grant such licensure by endorsement thus placing Mississippi at an unfair advantage in recruiting Canadian nurses.

The report of the reference committee was adopted.

Resolution No. 6, Equalization of Medicare Fees

Dr. Robert R. McGee:

WHEREAS, The Medicare fees in Mississippi have always been considerably lower than most of the fees for similar cases in the rest of the nation; and

WHEREAS, The United States senators receive exactly the same salary, regardless of what part of the nation they are from; and

WHEREAS, Postal workers receive the same hourly wages for equivalent work, regardless of what part of the nation they reside; and

WHEREAS, The American Medical Association is our only effective mechanism of dealing with the federal government; and

WHEREAS, The American Medical Association has seen fit only to table resolutions from Mississippi State Medical Association regarding this problem in the past; therefore be it

Resolved, That the Mississippi State Medical Association again through its delegates to the American

Medical Association insist on some relief from this intolerable situation; and

Be It Further Resolved, That until such time as the American Medical Association sees fit to make efforts to obtain relief for the physicians of Mississippi that the American Medical Association dues from Mississippi physicians be reduced in direct proportion to the relationship between Medicare rates in Mississippi and Medicare rates in the higher paid states of the nation.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

This resolution was introduced by Dr. Robert Ray McGee, delegate from Clarksdale and Six Counties Medical Society. This resolution states:

"Resolved, That the Mississippi State Medical Association again through its delegates to the American Medical Association insist on some relief from this intolerable situation; and

"Be It Further Resolved, That until such time as the American Medical Association sees fit to make efforts to obtain relief for the physicians of Mississippi that the American Medical Association dues from Mississippi physicians be reduced in direct proportion to the relationship between Medicare rates in Mississippi and Medicare rates in the higher paid states of the nation."

Your reference committee is concerned about the inequitable situation which this resolution is designed to correct, therefore, we recommend adoption of the following substitute resolution:

"Resolved, That the MSMA again through its delegates to the AMA insist on some relief from this intolerable situation."

The report of the reference committee was adopted.

Resolution No. 7, Limits on Testimony in Rape Cases

Dr. Robert R. McGee:

WHEREAS, Rape is a legal, rather than a medical phenomenon; and

WHEREAS, Many physicians are reluctant to become involved in examining a suspect rape case because of the lengthy and time-consuming legal procedures often required by these cases; and

WHEREAS, Several states now have laws which specifically deny calling physicians to court to testify in suspected cases of rape; now therefore be it

Resolved, That the Mississippi State Medical Association through its legislative committee make every effort to have the Mississippi Legislature pass

a law relieving physicians of the responsibility of appearing in court cases that they have examined in suspect cases of rape, and that a dissertation of the examination be accepted.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils

This resolution was introduced by Dr. Robert Ray McGee, delegate from Clarksdale and Six Counties Medical Society. This resolution states that:

"Resolved, That the MSMA through its legislative committee make every effort to have the Mississippi Legislature pass a law relieving physicians of the responsibility of appearing in court cases that they have examined in suspect cases of rape, and that a dissertation of the examination be accepted."

Your reference committee is reluctant to approve this resolution since a fundamental precept of our criminal justice system is the right of an accused to be confronted by and to cross-examine anyone who presents evidence bearing on the issue of his guilt. Additionally, your committee feels that we as physicians have a professional and civic responsibility that goes beyond curing disease or illness. However, due to the fact that no one spoke against this resolution your reference committee recommends its adoption.

In discussion Dr. Calvin T. Hull of Jackson, and Dr. W. L. Kahlstorf of Tupelo spoke against the reference committee recommendation. Dr. Donald R. Ellis of Clarksdale spoke for the reference committee recommendation.

After discussion the recommendation of the reference committee was defeated.

The report of the reference committee was adopted as amended.

Auxiliary Officers

The speaker presented Mesdames W. A. Brown, Jr., of Mathiston, 1976-77 president of the MSMA Auxiliary, and William Hilbun, Jr., of Meridian, 1977-78 president, who addressed the House of Delegates. Mrs. Norman Gardner of East Hampton, CT, president of the AMA Auxiliary, also spoke to the delegates about activities on the national level. New president-elect of the MSMA Auxiliary is Mrs. G. Sam Rowlett of Vicksburg.

1977 MSMA-Robins Award

President-elect Gilmore presented the 1977 Mississippi State Medical Association-Robins Award for outstanding community service by a physician to Dr. Hugh Banks Barnes of Hattiesburg. Dr. Barnes was

cited for his work in establishing a drug control system for local schools, the formation of community bands, health education and first aid instruction for schools and community agencies and other community oriented services. Mr. Willard Duval from the A. H. Robins Company of Richmond, VA, assisted Dr. Gilmore in the presentation of the award, an engraved plaque.

AMA-ERF

President-elect Gilmore presented the yearly contribution to the American Medical Association—Education and Research Fund by physicians, their families and Ole Miss Medical Alumni to UMC Vice Chancellor and Dean Norman Nelson. Dr. Charles Farris of New Orleans, medical alumni association president, and Mrs. Pat Warfield of Moss Point, Auxiliary AMA-ERF chairman, were also present when the check for \$13,452.20 was given to the medical center. Dr. Nelson expressed thanks and pledged continued support and unity from the medical center.

Presentation of Scientific Exhibit Awards

Dr. J. Elmer Nix of Jackson, chairman of the Council on Scientific Assembly, announced the awards for outstanding scientific exhibits. "Cardiac Valve Replacement," by Drs. Martin H. McMullan and Thomas L. Kilgore of the Mississippi Baptist Medical Center in Jackson received the first place Aesculapius Award, an engraved walnut plaque, for best exhibit by members of the association. "Acquired Heart Disease—Diagnostic Methods and Surgical Therapy," by Drs. James L. Crosthwait, Quinton H. Dickerson, James C. Hays, Jeff F. Hollingsworth, W. Arthur Jones, George K. McMullan, W. H. Rosenblatt, and Henry B. Tyler, Mississippi Heart Institute, St. Dominic-Jackson Memorial Hospital, received the second place award in the member category. "Ventricular Aneurysm," by Drs. John L. Ochsner, Noel L. Mills, Tommy Fudge and David Glassford of Ochsner Clinic, New Orleans, was winner of the Scientific Achievement Award, a sculptured bronze medallion, in recognition of the best presentation by a nonmember.

Report of the Reference Committee on Rules and Order of Business

Conduct of Business. Your reference committee commends the speaker and vice-speaker for the outstanding manner in which they have conducted business before this House of Delegates. We believe that

HOUSE OF DELEGATES / Continued

all members will wish to associate themselves in this expression of appreciation.

Resolution. The reference committee desires to offer the following resolution for consideration by the House of Delegates:

WHEREAS, The 109th Annual Session of the Mississippi State Medical Association has been conducted at Biloxi, Mississippi, during the period May 2-5, 1977; and

WHEREAS, The annual session has been most profitable and enjoyable for all who have been in attendance; now therefore be it

Resolved, That expressions of deep appreciation are made to the officers, trustees and Council on Scientific Assembly for the stimulating and worthwhile scientific programs; to the management of the Sheraton-Biloxi and to other participating hotels and motels; to the press, radio and television for coverage of our activities; to the gracious ladies of the auxiliary who always contribute so substantially to our meetings; to the technical exhibitors and their professional service representatives; to our scientific exhibitors who have contributed to our learning and instruction; to our distinguished guests, particularly Dr. Richard E. Palmer of Alexandria, VA, president of the American Medical Association; and to all who have shared in the responsibilities of planning, organizing, conducting this great annual session and to our diligent and efficient staff.

Your reference committee recommends adoption of this resolution.

The report of the reference committee was adopted.

Report of the Election of Officers

President-elect: Carl G. Evers, Jackson

Vice Presidents: Matthew J. Page, Greenville; Joe M. Ross, Jr., Vicksburg; and David M. Owen, Hattiesburg

Delegate to AMA: G. Swink Hicks, Natchez (1979)

Alternate Delegate to AMA: Stanley A. Hill, Corinth (1979)

Associate Editor: Myron W. Lockey, Jackson (1979)

Board of Trustees: Arthur A. Derrick, Durant, District 4; Ellis M. Moffitt, Jackson, District 5; and Joe S. Covington, Meridian, District 6 (1980)

Council on Budget and Finance: Gerald P. Gable, Hattiesburg (1980)

Council on Constitution and By-Laws: W. Lamar Weems, Jackson (1980)

Judicial Council: Gerald A. Smith, Sumner, District 1; Wayne T. Lamar, Oxford, District 2; and Bruce E. Atkinson, Amory, District 3 (1980)

Council on Legislation: Walter H. Rose, Indianola, District 1; James W. Rayner, Oxford, District 2; and Richard H. Russell, New Albany, District 3 (1980)

Council on Medical Education: D. Stanley Hartness, Kosciusko, District 4; W. R. Gillis, Jackson, District 5; and William M. Hilbun, Jr., Meridian, District 6 (1980)

Council on Medical Service: William B. Hunt, Grenada, District 4; George Ball, Jackson, District 5; and Austin P. Boggan, Decatur, District 6 (1980)

Mississippi State Board of Health, nominees to governor for terms Jan. 1, 1978-Dec. 31, 1983: District 7—W. Moncure Dabney, Crystal Springs; David R. Stecker, Natchez; and John R. Young, Jr., Natchez. District 8—Robert L. Abney, III, Jackson; Wilfred Q. Cole, Jackson; and Maria J. Mangold, Yazoo City.

Official Attendance

The official attendance was announced as being 883 which included 408 members; 37 physician guests; 5 residents, interns and medical students; 41 non-physician guests; 171 exhibitors; 208 Auxiliary members and 13 staff and press.

Closing Ceremonies

There being no further business, the speaker gave the gavel to Board chairman, Dr. Robert S. Caldwell. The Oath of Office was administered to Dr. James O. Gilmore, the president-elect, by Dr. Caldwell, after which Dr. Gilmore addressed the House of Delegates.

It was announced that the Thompson Memorial Past President's Pin would be presented to Dr. Lyne S. Gamble at the University Hospital in Jackson by Mrs. James Grant Thompson, Dr. Carl G. Evers and Mr. Charles Mathews.

The House of Delegates was adjourned *sine die* at 11:30 a.m. in the morning, May 5, 1977.

Constitution and By-Laws of the Mississippi State Medical Association

CONSTITUTION

Preamble

That more may live longer in the richness and comfort of health; that pain, suffering, and disease may be eradicated to the extent made possible by scientific medical knowledge; that the standards of the medical profession may be maintained on the highest plane of honor, we dedicate ourselves as physicians through this Association. Among us, membership is a privilege, earned by professional qualification, personal honor, and selfless service; it is not a right vested superficially nor by statutory licensure. Truth shall be our quest; diligence, our staff; and service, our purpose.

Article I NAME OF THE ASSOCIATION

The name and title of this Association shall be the Mississippi State Medical Association.

Article II PURPOSE OF ORGANIZATION

The purpose of this Association shall be to federate and into one compact organization the entire medical profession of the state of Mississippi and to unite with similar associations in other states to form the American Medical Association, with a view toward the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws, to the promotion of friendly intercourse among the physicians and to guarding and fostering of their opinion in regard to the great problems of medicine, so that the profession shall become more honorable and capable within itself, and more useful to the public in the prevention and care of disease, and in the prolonging of and adding comfort to life.

The purpose of this Association shall be to promote scientific medical research and practice and it shall be a non-profit organization.

Article III COMPONENT SOCIETIES

Component Societies shall consist of those societies which hold charters from the Association.

Article IV MEMBERSHIP

Section 1. Members of the Mississippi State Medical Association. Members shall be active, associate, emeritus, or honorary, according to requirements and provisions of the By-Laws. There may also be invited guests. Membership other than associate and honorary shall be construed as active in connection with the rights and privileges accruing therefrom.

Section 2. Guests. Any physician not a resident of the state may become a guest during any annual session upon invitation of a member of the Association, and shall be accorded the privilege of participating in all the scientific work of that session.

Article V SESSIONS AND MEETINGS

Section 1. The Association shall hold an annual session during which there shall be held daily not less than two general meetings, which shall be open to all registered members and guests.

Section 2. The time and place for holding the annual session shall be fixed by the House of Delegates, but in emergencies, the Board of Trustees shall have the power to fix, or change, either the time or the place, or both of the annual session.

Article VI GENERAL OFFICERS

Section 1. The general officers of this Association shall be President, President-elect, three Vice-Presidents, one from each Supreme Court District, Secretary-Treasurer, Speaker, Vice Speaker, and Editor.

Section 2. The President, President-elect, and Vice-Presidents shall hold terms of one year. The Secretary-Treasurer, Speaker, Vice Speaker and Editor shall be elected for terms of three years.

Section 3. The officers of this Association shall be elected by the House of Delegates on the last day of the annual session following the adjournment of the general meeting, but no person shall be elected to any such office who has failed to attend one of the past two or current annual sessions and who has not been a member for the past two years.

Section 4. In addition to these general officers, there shall be an Executive Secretary who need not be a physician or member of the Association. He shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. His compensation and expenses for duties performed shall be fixed by the Board of Trustees and confirmed by the House of Delegates.

Article VII EXECUTIVE OR CENTRAL OFFICES

The Executive Secretary shall maintain in the city of Jackson suitable offices for the discharge of his duties and for conducting the administrative affairs of the Association.

Article VIII HOUSE OF DELEGATES

The House of Delegates shall be the legislative, business, and policy-making body of the Association and shall consist of (1) delegates selected by the component societies under authorized apportionment, (2) the general officers of the Association, (3) all past presidents, provided they still be members in good standing of the Association, (4) members of the Board of Trustees and Councils, and (5) elected committees, Delegates and Alternate Delegates to the American Medical Association and members of the State Board of Health, all of whom must be members of this Association.

Article IX BOARD OF TRUSTEES

The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of

Delegates and shall perform such duties as are prescribed by law governing directors of corporations and in the By-Laws of the Association. The Board shall consist of 12 members, one from each of the nine Association Districts, except Association District V which is authorized two members, elected for terms of three years each and the President and Immediate Past President. A Trustee shall not serve more than two consecutive terms and no member shall be eligible for re-election to the Board of Trustees after serving two consecutive terms until that individual has been off the Board for at least six years.

Article X FUNDS AND EXPENSES

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by annual dues, per capita assessments upon the membership, and by voluntary contributions. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, publications, and for any other purpose approved by the House of Delegates.

Article XI THE SEAL

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been sent officially to each component society at least two months before the session at which final action is taken.

BY-LAWS Chapter I MEMBERSHIP

Section 1. Eligibility. Each component society of the Mississippi State Medical Association shall judge the qualifications of candidates for election to membership therein, which shall be restricted to those persons who hold the degree of Doctor of Medicine from an appropriately accredited source as defined by the American Medical Association, or in lieu thereof, a foreign degree in medicine which is an acceptable equivalent to the Board of Trustees and shall be a citizen of the United States. All candidates for any degree of membership other than associate or honorary must be legally licensed to practice medicine in Mississippi. Persons who obtained this degree prior to January 1, 1917, need not comply with this requirement but must be licensed to practice medicine in Mississippi or, if offering to practice in Mississippi must be eligible for license by reciprocity and be a member in good standing of a constituent (state) association of the American Medical Association. Membership in a component society, evidenced by the payment of dues for the current year, shall be a prerequisite to membership in the Association, except that a physician upon his initial application for membership in a component society of the Association shall be required to undergo a waiting period of ninety (90) consecutive days from the date he begins the practice of medicine in the geographical area of the component society before he may be elected to membership in the component society. No physician shall be eligible for membership who has been convicted of or who has plead guilty to either a felony or a violation of a state or federal narcotics law. The duly certified court record shall be *prima facie* evidence

of pleas and convictions and cause automatic revocation of membership. No physician shall be eligible for election to or continuation of membership who does not possess a currently effective federal narcotics stamp, provided, however, that physicians in full time government service who need no registration to use, prescribe, and dispense narcotic drugs and those who, by reason of type of practice, employment, inactivity, or retirement, neither prescribe nor dispense narcotics and who for this reason alone have not applied for registration shall be exempt from this requirement. Also, any member of the association who voluntarily surrenders his federal narcotics stamp and places himself in a rehabilitation program recommended by that examining committee of physicians composed under the Mississippi Disabled Physician Act of 1975 shall be exempt from this requirement.

Section 2(a). Good Standing. Only those members in good standing shall be entitled to the rights and privileges of membership. A physician not in good standing may not be elected to office nor exercise the privilege of voting or attending any session of this Association, scientific or otherwise. The name of a physician upon the properly certified roster of a component society which has paid its annual assessment shall be *prima facie* evidence of his right to register at the annual session of the Mississippi State Medical Association. No member shall participate in any of the proceedings of the annual session until he is duly registered. No delegate or other member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this session. (b) Change of State Residence. In the event that a member moves from the State, his membership shall continue until, and lapse at the end of, the current fiscal year, but this provision shall not operate to prevent a physician who moves from the state continuing his membership by payment of all dues and assessments to the state Association). (3) Obligations of Membership. When the Executive Secretary of the Mississippi State Medical Association is officially informed by the secretary of a component society that a physician is not in good standing in the component society, he shall remove the name of the physician from the rolls of the Association. A member shall hold his membership through the component society in the jurisdiction of which he practices, provided that a physician living on or near a county line may hold membership in the society most convenient for him to attend. If the society in which he chooses to secure membership does not exercise jurisdiction over the area of his residence, then permission must be obtained from the jurisdiction society to facilitate his affiliation with the extra-jurisdiction society.

Section 3. Degrees of Membership. Members of the Mississippi State Medical Association shall be divided into the following classifications: Active, emeritus, and associate. (a) Active Membership. Active members shall include all eligible members of component societies in good standing, providing that all dues and assessments in this Association as may be hereinafter prescribed have been received by the Association. (b) Emeritus Members. Any member of the Mississippi State Medical Association who has been an active member for any ten consecutive years and shall have permanently retired from the practice of medicine shall be eligible for election to emeritus membership. Election to emeritus membership for reasons of retirement in the case of permanent and total disability shall merit special consideration but shall be subject to ruling by the Board of Trustees. Election to emeritus membership shall be based on the recommendation of the component society and the approval of the Board of Trustees. (c) Associate Membership. Any commissioned medical officer in the United States Army, United States Air Force, United States Navy, or United States Public Health Service, or any physician in the employ

of the Veterans Administration, not licensed to practice in the State of Mississippi, stationed in Mississippi, members of medical faculties of medical schools in Mississippi, approved by the American Medical Association, who are not licensed to practice in the state, any hospital intern, or any hospital resident in Mississippi, may, on election to associate membership by the component society in whose jurisdiction the physician resides become an associate of the Mississippi State Medical Association. Associate members shall not vote or hold office. (d) Honorary Membership. A layman who has rendered meritorious service may on approval and nomination by the Judicial Council be elected to honorary membership by majority vote of the House of Delegates. Honorary members shall not vote or hold office.

Section 4. Dues and Assessments. A per capita assessment determined by the House of Delegates shall constitute the dues of the Association, which assessment shall be collected from all active members by the respective secretaries of the component societies, provided that new members shall be accepted on payment of three-fourths of annual dues after May 1 and one-half of annual dues after September 1. Each active member shall pay the prescribed dues to the officer designated by the component society for transmittal to the Executive Secretary of the Association. Dues shall include a subscription to the official publication of the Association. (a) Members Excused From Payment. The Board of Trustees may, by majority vote, excuse a member from payment of dues because of undue hardship or similar circumstances warranting special consideration provided that the component society shall have excused in full the payment of dues for periods exceeding one year. Such circumstances shall be interpreted to include extended illness and temporary disability. Members who shall have attained age 70 and who have been active members of the Association for any 10 consecutive years may, upon request, be exempt from dues for life effective January 1 after the 70th birthday, and such exemption shall continue so long as the member continues in good standing in his component medical society. (b) Emeritus Members. Physicians who have been elected emeritus members shall not be required to pay dues in the Association. (c) Payment of Dues and Delinquency. Dues of the Association are due and payable on December 31 of the year prior to that for which dues are prescribed. Failure to pay dues by April 1 of the year for which due shall result in forfeiture of membership privileges and the removal of the member's name from the rolls of the Association. A five dollar (\$5.00) reinstatement cost shall be assessed against any member who is delinquent by reason of non-payment of dues after April 1 of the year for which dues are payable. A member in good standing who is called to active duty with the Armed Forces of the United States other than in the regular component shall be carried as an active member without payment of dues until such time as he is released from military service.

Section 5. American Medical Association. Members of this Association desiring to be members of the American Medical Association may pay the dues or apply when eligible, for legal exemption from the dues of the American Medical Association. Those desiring to do so may pay their dues to the Executive Secretary whose duty shall be to transmit them to the American Medical Association and to obtain proper credits and receipts therefor.

Section 6. Revocation of Emeritus or Associate Membership. Any emeritus or associate membership may be revoked by two-thirds vote of the House of Delegates when, in the opinion of the House of Delegates, the conduct or actions of the emeritus or associate member violates any of the principles of the code of ethics or whose conduct or actions are not becoming to the honor conferred.

Chapter II ANNUAL AND SPECIAL SESSIONS

Section 1. Time and Place. An annual session shall be held as required by Article V, Section 1, the Constitution of the Mississippi State Medical Association, which session shall in any event be held prior to the annual session of the American Medical Association. The place of the state session shall be fixed in accordance with Article V, Section 2, the Constitution of the Mississippi State Medical Association.

Section 2. Special Session. A special session of the Association or of the House of Delegates may be called by the President, with the approval of the Board of Trustees. The Board of Trustees is empowered to call a special session by majority concurrence.

Section 3. Inviting an Annual Session. A component society desiring the Association and House of Delegates to meet in annual session in a city within its jurisdiction may submit an invitation in writing or verbally through its representative to the House of Delegates at the annual session concerned with the selection of the site for the next regular scheduled meeting. The dates and site of the annual session selected may be changed by majority vote of the Board of Trustees in an emergency requiring such a change.

Section 4. Registration Privileges. Only the following shall be permitted to register at any session:

- (a) Active members
- (b) Emeritus members
- (c) Associate members
- (d) Honorary members
- (e) Invited guests
- (f) Medical students of American Medical Association approved medical schools who are certified to the Executive Secretary of the Association by their respective deans.
- (g) Interns and residents who are graduates of American Medical Association approved medical schools and who are connected with an approved hospital and who are certified to the Executive Secretary of the Association by their respective hospital superintendents in event they are not associate members of the Association.
- (h) Commissioned medical officers of the United States Armed Forces who are on active duty and who if not associate members are certified to the Executive Secretary by their Post or Base Surgeons or Commanding Officers.

Section 5. Indebtedness. A member shall not be permitted to register unless all current indebtedness to both the Association and component of proper jurisdiction has been paid.

Section 6. Admittance. Admittance to any meeting of the House of Delegates, any scientific section, or any of the various exhibits at an annual session of the Association shall be limited to members in good standing, duly registered and invited guests, members in good standing of the Woman's Auxiliary to the Mississippi State Medical Association, duly accredited and registered members of the Press, and accredited technical and scientific exhibitors.

Chapter III GENERAL MEETING

Section 1. Participation. The general meeting shall include all registered members and guests, who shall have equal rights to participate in the proceedings and discussions, but no member shall vote on any question coming before a sec-

tion of the general meeting except those who have registered as members of such sections. Each section of the general meeting shall be presided over by its chairman. The address of the President and the Distinguished Service Oration shall be delivered before the general meeting at such time and place as may be arranged.

Section 2. Order. The order of exercise, papers, and discussions as set forth in the official program shall be followed from day to day until it has been completed. But no section shall be allowed to place more than five papers on its program, nor more than two invited guest essayists (out-of-state or non-member). When a section program is not completed within the time assigned, it shall not be allowed to continue into that assigned to another section.

Section 3. Time Restrictions. No address or paper before the Association, except those of the President and Orator, shall occupy more than twenty minutes in its delivery, except that guests may be allowed thirty minutes; and in formal discussion no one shall speak more than five minutes; and in informal discussion no one shall speak more than three minutes and not more than one time.

Section 4. Essayists. With the exception of the invited guests, the essayists must be members of the Association. No name shall appear more than once on the printed program to discuss a paper before the regular scientific sections unless such person qualifies for membership as provided in these By-Laws.

Section 5. Papers. All papers read before the Association shall be its property. Each paper must be read by its author, and must be deposited with the Secretary when read.

Section 6. Failure to Read Paper. No author listed on the program who fails to read a paper at the session may be allowed a place on the program of the next annual session, but if the author, being unable to attend, shows his good intent by forwarding his paper to the Secretary before the annual session, he shall not suffer the penalty.

Chapter IV SCIENTIFIC SECTIONS

Section 1. Designation of Sections. The scientific sections of the Association shall be as follows: (a) Section on Medicine, (b) Section on Surgery, (c) Section on Preventive Medicine, (d) Section on Eye, Ear, Nose and Throat, (e) Section on Pediatrics, (f) Section on Obstetrics and Gynecology, (g) Section on General Practice, (h) Section on Anesthesiology, (i) Section on Radiology, (j) Section on Pathology, (k) Section on Psychiatry, (l) Section on Dermatology, and (m) Section on Orthopedic Surgery.

Section 2. Section Officers. Each scientific section of the Association shall, as the last order of business during its regular meeting, elect a chairman who shall serve for a period of one year. A majority of votes cast shall be necessary to elect. Additionally, each section shall elect a secretary whose term of office shall be for a period of three years and so arranged that secretaries shall be elected by their respective sections at the same annual meeting as follows: (1) Sections on General Practice, Anesthesiology, and EENT, (2) Sections on Obstetrics and Gynecology and Preventive Medicine, and (3) Sections on Pediatrics, Surgery, and Medicine.

Section 3. Program. The Council on Scientific Assembly shall place any paper in its proper section. The Council shall so arrange the program that no one section shall be given precedence over others two years in succession.

Chapter V HOUSE OF DELEGATES

Section 1. Apportionment and Representation. Each organized county shall be entitled to representation in all regular and special sessions of the House of Delegates, one delegate

and one alternate for each fifty members in the county and one delegate and one alternate for each fraction thereof, but each organized county holding a charter from this organization having made its annual report and paid its assessments, as provided in this Constitution and By-Laws shall be entitled to at least one delegate and alternate, said alternate delegates to act only in the absence of the delegate or delegates from the respective counties. No county in a component society shall be without representation in the House of Delegates; each shall be entitled to one delegate and one alternate without regard to total membership. No alternate may be seated at any regular or special session of the House of Delegates unless the delegates elected from that county shall be absent or otherwise unable to participate in the proceedings. In the event that neither the delegate nor the alternate is able to attend the regular or special session to which they have been accredited, then any *bona fide* resident of the county may, if properly registered, qualify himself as a delegate. No representative of the component society shall be seated in the House of Delegates until all his dues, assessments, and obligations to the component society have been paid. Delegates and alternates shall be elected by their respective component societies for terms of not less than two years and shall assume office on the first day of the annual session following their elections; they shall be *bona fide* residents of the counties which they represent. Their names shall be reported to the Central Office of the Association not later than thirty days prior to the first day of the annual session. Representatives of component societies shall be seated in the House of Delegates only following their proper registration of credentials from the component societies they represent.

Section 2. Meetings and Attendance. The House of Delegates shall meet annually on the first day of the annual session of the Association. The House of Delegates shall meet for the conclusion of business on the last day of the annual session immediately following the adjournment of the last general or scientific session, provided that these requirements shall not operate to prevent such other meetings of the House of Delegates during the annual session as the House itself may order or the President or Speaker may deem necessary, but no such meetings may be called at times which would conflict with the scheduled general or scientific session. Duly registered members and guests may attend all meetings of the House of Delegates provided that they occupy a distinctly separate section of the meeting hall or auditorium and further provided that they shall not be permitted to participate in any phase of the meeting of the House of Delegates except on invitation of that body. By majority vote, the House of Delegates may enter into executive session, during which time only qualified delegates and officers of the Association may remain in attendance.

Section 3. Quorum. A three-fifths majority of registered and duly seated delegates of this Association shall constitute a quorum.

Section 4. Order of Business. The order of business shall be conducted at the pleasure of the House of Delegates, provided it shall not be in conflict with either these By-Laws or the Constitution. Meetings shall be conducted according to *Sturgis Standard Code of Parliamentary Procedure*, and within the bounds of courtesy and this Constitution and By-Laws. Generally, the order of business shall be:

- (1) Adoption of the Transactions of the previous meeting.
- (2) Reports of Boards, Councils and Committees.
- (3) Reports of Presidential Committees.
- (4) Special Orders.
- (5) Unfinished Business.
- (6) New Business.

Section 5. Memorials and Resolutions. No memorials or resolutions shall at any time be issued in the name of the Mississippi State Medical Association by any officer or member thereof until such memorial or resolution has been approved and adopted by the House of Delegates or Board of Trustees.

Section 6. Duties and Responsibilities. It shall, through its officers and otherwise, give diligent attention to foster the scientific work and spirit of the Association, and shall constantly study and strive to make each annual session a stepping stone to future ones of higher interest. It shall consider and advise the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto. It shall make careful inquiry into the condition of the profession of each county in the state, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in the counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every physician in every county in the state has been brought under medical society influence. It shall encourage postgraduate work in medical centers, as well as home study and research, and shall endeavor to have the results utilized and intelligently discussed in the component societies. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body, the term of office to begin on January 1 of the year following that of the elections and continuing for two successive years. It shall, upon recommendation of the Board of Trustees, provide and issue charters to counties organized to conform to the spirit of the Constitution and By-Laws.

Section 7. Reference Committees. Business brought before the House of Delegates will normally be referred by the Speaker for hearing, debate, and recommendation to a reference committee. Sufficient reference committees shall be appointed by the President to expedite and assist in the deliberations of the House of Delegates. Such committees shall consist of not less than three nor more than five members, all of whom shall be members of the House of Delegates, who shall serve only during the regular or special session for which appointed. Any member of the Association shall have the privilege of appearing before a reference committee on any issue being considered. Additionally, reference committees may permit the appearance of any individual who, in the opinion of the committee, can assist its deliberations.

Chapter VI ELECTION OF OFFICERS

Section 1. Ballot. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect.

Section 2. Nominations. The House of Delegates on the first day of the annual session shall select a Committee on Nominations consisting of nine members of the House of Delegates, one from each Association District. It shall be the duty of this committee to consult with the members of the Association and to hold one or more meetings at which the best interests of the Association and of the profession of the state for the ensuing year shall be carefully considered. The committee shall nominate to the House of Delegates three names for each general officer vacancy and two names for all other offices. No two candidates for President-elect may

be named from the same county. Nominations for appointment to membership on the Mississippi State Board of Health shall be made by the House of Delegates in accordance with Section 7024, Mississippi Code of 1942, provided that six names shall be submitted, three of whom shall be elected and their names submitted to the Governor as nominees from each district, provided no member shall be nominated who has served two consecutive terms.

Section 3. Report of Nominations. The House of Delegates shall receive the report of the Committee on Nominations and elect officers, Trustees, and Council members on the last day of the annual session.

Section 4. Nominations from the Floor. Nothing in this Chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 5. Executive Secretary. The Board of Trustees shall select and appoint an Executive Secretary as elsewhere prescribed in the Constitution and By-Laws of the Association.

Chapter VII DUTIES OF OFFICERS

Section 1. President. The President shall have general supervision over all meetings of the various bodies of the Association, shall appoint all committees not otherwise provided for, shall deliver an annual address at such time and place as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall fill by appointment all vacancies occurring during his tenure of office among the general officers and on the Board of Trustees and Councils and shall be empowered to appoint such committees on an *ad hoc* basis as may be desired or required to conduct the affairs of the Association. He shall be an *ex officio* member of all Councils and committees. He shall be the real and acknowledged head, as well as the personal representative, of the medical profession of the State of Mississippi during his term of office, and insofar as practicable, shall visit by appointment the various sections of the state and the component societies of the Mississippi State Medical Association and assist the Trustees in their tasks of aiding and strengthening the component societies and in making their work more useful.

Section 2. President-elect. The President-elect shall be in charge of the work of organization, including membership, under the direction of the President, and shall exercise these duties and advise with the Vice Presidents and with the Board of Trustees in this phase of their activity. He shall be an *ex officio* member of all Councils and committees. He shall succeed to the presidency upon the event of the death, resignation, or removal from office of the President. This automatic succession shall not operate to disqualify him from serving the next regular term of office unless he has served more than six months as President.

Section 3. Vice Presidents. The Vice Presidents shall assist the President in the discharge of his duties. They shall further assist the President-elect in the work of organization, including membership in their respective areas, and in promoting the welfare of the Association and the profession of the state.

Section 4. Speaker. A Speaker shall be elected for a term of three years. This officer may be chosen from the membership of the Association, irrespective of any affiliation with the House. The Speaker shall familiarize himself with the rules and usages of parliamentary procedure, with the laws of the House. On him shall devolve the duty of bringing before the House through the various officers and chairmen all

reports and other matters that are to receive its attention. He shall preside at all meetings of the House and perform the duties usual to the position and office of chairman except in the appointment of committees, which shall be the privilege of the President.

Section 5. Vice Speaker. A Vice Speaker shall be elected for a term of three years to run concurrently with that of the Speaker. The Vice Speaker shall assist the Speaker in all duties prescribed in these By-Laws.

Section 6. Secretary-Treasurer. The Secretary-Treasurer shall be elected for a term of three years. He shall perform such duties ordinarily devolving on a secretary of a corporation by law, custom, or parliamentary usage and shall enjoy the rights and perform such other duties as may be granted or imposed in the Constitution and these By-Laws. He may delegate such duties as are herein described to the Executive Secretary who shall be responsible therefor. He shall be an *ex officio* member of all Councils and committees.

Section 7. Executive Secretary. The Executive Secretary shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. He need not be a member of the Association nor a physician. He shall maintain a Central Office for the Association and shall be responsible for the management and proper functioning of the Central Office to the President of the Association and the Board of Trustees. He shall attend all sessions and meetings of the Association, the House of Delegates, the Board of Trustees, and shall serve at all times to perform such other duties as may be deemed beneficial to the Association by the President and Board of Trustees. He shall assist elected officers, Councils, committees, and Trustees in the performance of their duties. Under instructions from the President, he shall conduct a comprehensive program of public education and all such other activities as may disclose favorably to the public at large the aims, objectives, and goals of service of the medical profession in Mississippi. He shall, when requested, place himself in position to assist any of the component societies of the Association and he shall attend meetings of the component societies when invited by officers thereof. He shall be made custodian of records, books and papers belonging to the Association and he shall keep account of and promptly place under the supervision of the Secretary-Treasurer such funds as may be delivered into his hands in the name of the Association. He shall give bond at the expense of the Association in such amount as may be required. He shall provide for the registration of the members and delegates at the annual session and cooperate in preparing for and arranging all functions of the Association, including the annual session. He shall procure an exact transcript of all proceedings of the House of Delegates. He shall maintain a register of all legal practitioners in Mississippi and he shall maintain detailed and exact records of the membership with regard to component societies, the Mississippi State Medical Association, and the American Medical Association. He shall issue evidence of membership to each physician who pays the annual assessment and is accepted in the Mississippi State Medical Association. He shall maintain close and complete liaison with the American Medical Association and shall keep the component societies informed of activities, programs, and mandates of both the state Association and the American Medical Association. He shall publish from the Central Office such memoranda, bulletins, and miscellaneous publications as may be directed by the President, the Board of Trustees, and the House of Delegates. He shall conduct the official correspondence of the Association as he may be directed. He shall employ such assistants as may be required, upon authorization of the Board of Trustees. He shall supply each component society with blank forms to be used in connection with membership and reports. He shall

maintain records of monies paid by the component societies for assessments and dues. He shall prepare and publish under the direction of the President and Board of Trustees such programs as may be necessary for official functions of the Association. He shall be reimbursed for expenses incurred in the performance of his duties, separately and in addition to his regular compensation.

Chapter VIII BOARD OF TRUSTEES

Section 1. Board of Trustees. The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates. It shall consist of 12 members, one from each Association District, except Association District V which is authorized two members, whose terms of office shall be three years. A Trustee shall not serve more than two consecutive terms. No member shall be eligible for re-election to the Board of Trustees after serving two consecutive terms until that individual has been off the Board for at least six years. The President and Immediate Past President of the Association shall also serve on the Board of Trustees. During vacation, the Board of Trustees shall exercise the powers conferred upon the House of Delegates by the Constitution and these By-Laws, provided that in the exercise of these powers thus conferred, the Board of Trustees shall neither consider nor act to contravene any action, mandate, or policy of the House of Delegates which may still be in effect.

Section 2. Officers of the Board. The Board of Trustees shall elect from its membership a Chairman, a Vice Chairman, and a Secretary for terms of one year during the last day of the annual session following adjournment of the House of Delegates. These officers of the Board shall compose its Executive Committee. The duties of the Secretary may be delegated to the Executive Secretary who shall maintain such special records and transcripts of meetings as the Board may desire.

Section 3. Meetings of the Board. The Board of Trustees shall meet daily during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of any three members of the Board.

Section 4. Executive Committee. The Executive Committee of the Board of Trustees shall be empowered to act in behalf of the Board on all matters delegated to it by majority vote of the Board. The acts of the Executive Committee, however, shall be subject to confirmation by the Board.

Section 5. Reports of the Board of Trustees. The Board of Trustees shall make an annual report to the House of Delegates and such supplemental reports as necessity may require at a time designated in the regular transaction of the business of the House. The report shall be made by the Chairman, the Vice Chairman, the Secretary, or the Executive Secretary. The reports of the Board shall be made a portion of the annual transactions and proceedings of the Association.

Section 6. Duties of Trustees. Each Trustee shall be organizer and arbiter for his Association District. He shall visit the component medical societies within his District during each year and shall make an annual report of his activities and of the condition of the medical profession of each county of his District. Each Trustee shall be reimbursed for expenses incurred by him in traveling within his District or attending special meetings in the performance of his official duties, which will be allowed upon presentation of an itemized and documented account. This provision shall not be construed to include his expenses in attending the annual session of the Association.

Section 7. Public Policy. The Board of Trustees shall have the right to communicate the views of the medical profession and of the Association in the State of Mississippi with regard to matters of medical science, health, sanitation, and allied spheres of activity. It shall approve all memorials and resolutions issued but shall not issue memorials and resolutions heretofore prohibited in these By-Laws.

Section 8. Association Districts. The State of Mississippi shall be subdivided into Association Districts by counties, provided that all counties in a component society shall be in one Association District. These districts are defined as follows:

- District 1: Bolivar, Coahoma, Humphreys, Leflore, Quitman, Sunflower, Tallahatchie, Tunica, and Washington.
- District 2: Benton, DeSota, Lafayette, Marshall, Panola, Tate, Tippah, and Yalobusha.
- District 3: Alcorn, Calhoun, Chickasaw, Clay, Itawamba, Lee, Lowndes, Monroe, Noxubee, Oktibbeha, Pontotoc, Prentiss, Tishomingo, and Union.
- District 4: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, and Webster.
- District 5: Hinds, Issaquena, Leake, Madison, Rankin, Scott, Sharkey, Simpson, Warren, and Yazoo.
- District 6: Clark, Kemper, Lauderdale, Neshoba, Newton, and Winston.
- District 7: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Pearl River, Perry, Smith, and Wayne.
- District 8: Adams, Amite, Claiborne, Copiah, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, and Wilkinson.
- District 9: Hancock, Harrison, Jackson, and Stone.

Chapter IX COUNCILS

Section 1. Councils. Councils of the Association shall be elected standing bodies of the House of Delegates, responsible thereto. There shall be a Council on Medical Service, a Council on Scientific Assembly, a Judicial Council, a Council on Constitution and By-Laws, a Council on Legislation, a Council on Budget and Finance, an Editorial Council, and a Council on Medical Education. A Council member shall not serve more than two consecutive terms. No member shall be eligible for re-election to a Council on which he or she has served two consecutive terms until that individual has been off that council for at least six years.

Section 2. Council on Medical Service. The Council on Medical Service shall be charged with the responsibilities of ascertaining and studying all aspects of medical care in Mississippi. It shall examine and make available all facts, data, and opinion on timely and adequate medical care. It shall investigate social and economic aspects of medical care and report its evaluations and findings. It shall suggest means of distribution of adequate quality medical service to the public consistent with the policies of the Association. It shall act as a factfinding and advisory body of the Association. Under its jurisdictions, there shall be assigned the activities of the Association in medical service, emergency service programs, indigent care, and allied medical agencies. There shall be one member from each Association District elected for a term of three years and so arranged that only three members shall be elected for full terms each year. The Council on Medical Service shall appoint Committees on Maternal and Child Care, Mental Health, Blood and Blood Banking, and Nursing. Each committee shall consist of not less than five nor more than seven members appointed for

periods of not less than one nor more than three years.

Section 3. Council on Scientific Assembly. The Council on Scientific Assembly shall be composed of the Secretary-Treasurer and the chairman and secretaries of the several scientific sections. The Secretary-Treasurer shall be chairman of the Council. Upon this Council shall devolve the duties and responsibilities of planning the annual session to include all scientific activity and the programming and scheduling of annual session events. The Council shall be empowered to appoint such committees for terms not to exceed one year as may be necessary to assist in the discharge of these duties.

Section 4. Judicial Council. The Judicial Council shall consist of nine members elected for terms of three years each, one from each Association District. The Judicial powers of the Association shall be vested in this Council whose decision shall be final. The Council shall have jurisdiction in all questions involving membership in the Association, all controversies arising under the Constitution and these By-Laws, interpretation and application of the Principles of Medical Ethics of the American Medical Association, controversies between two or more component societies of the Association and among members of the Association. The Council shall have appellate jurisdiction in questions and controversies referred to the state Association by appropriate and authorized bodies of component medical societies. Appeals shall be perfected within six months following the date of decision by the constituted authority of the component society. The Council, under these several authorities, may conduct such hearings as may be necessary and after due and legal processes may, by majority opinion, censure, suspend, or expel any member for infraction of the Constitution or these By-Laws.

Section 5. Council on Constitution and By-Laws. The Council on Constitution and By-Laws shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be referred all suggested amendments and changes in the Constitution and By-Laws of the Association for recommendation to the Board of Trustees and House of Delegates.

Section 6. Council on Legislation. The Council on Legislation shall consist of nine members, one from each association district, elected by the House of Delegates for terms of three years each which are so arranged that three members are elected annually. This Council shall analyze proposed legislation, recommending to the Board of Trustees courses of action for securing laws in the interests of public health, scientific medicine, as well as medical practice. It shall study and report the need for new and remedial legislation designed to serve the best interests of the state and nation. This Council shall be responsible to the Board of Trustees.

Section 7. Council on Budget and Finance. The Council on Budget and Finance shall consist of five members elected by the House of Delegates for terms of three years each which are so arranged that not more than two members shall be elected annually. This Council shall receive reports of the finances of the Association and to it shall be referred all matters pertaining to the annual budget. The Council shall report annually to the House of Delegates, making specific recommendations on the annual budget of the Association. This Council shall be responsible to the Board of Trustees.

Section 8. Editorial Council. The Editorial Council shall consist of the Editor and the Associate Editors, elected by the House of Delegates to serve two years, and the former shall serve as chairman. To this Council shall be referred all reports of scientific subjects and all scientific papers and

discussions presented before the Association and its component societies. The Council shall consider for publication in the official organ of the Association such papers, reports, and other data as may serve to further and advance scientific medicine in Mississippi. It shall exercise editorial authority over the official organ of the Association. This Council shall be responsible to the Board of Trustees.

Section 9. Council on Medical Education. The Council on Medical Education shall consist of one member elected from each association district for terms of office of three years and whose initial terms are so arranged that no more than three members are elected annually. To this Council shall be assigned the responsibilities of encouraging undergraduate and postgraduate study of medicine, licensure, and facilities for medical education in the state. This Council shall be responsible to the Board of Trustees.

Chapter X COMMITTEES OF THE BOARD OF TRUSTEES

Section 1. Committees of the Board of Trustees. Standing committees of the Board of Trustees shall consist of the Advisory Committee to the Medical Auxiliary, Peer Review Committee, the Committee on Publications, and the Committee on Medicine and Religion. All committees of the Board of Trustees shall be appointed by the Board for terms specified unless their selection is otherwise prescribed.

Section 2. Advisory Committee to the Medical Auxiliary. The Advisory Committee to the Medical Auxiliary shall consist of three members appointed for terms of three years each. The committee shall be charged with the responsibility of advising the Woman's Auxiliary to the Mississippi State Medical Association on matters of organization and program activity relating to the supportive role of the Auxiliary in its work with the Association.

Section 3. Peer Review. The Committee on Peer Review shall consist of nine members, one from each Association district, appointed for terms of three years each so as to provide for appointment of three members annually. Members of this committee shall not simultaneously serve on any disciplinary body of the Association or its component medical societies. To this committee shall be assigned the work of peer review, including but not limited to resolution of differences between patient and physician, review of the quality of medical care, adequacy and/or reasonableness of fees, whether due or paid from private or public sources, utilization of health care resources, and liaison with private and public sources of medical care financing. The committee is empowered to encourage a response from any member of the Association in writing or by personal appearance, authority to initiate investigations on its own motion, and authority to file charges against a member in the name of the committee before the Judicial Council or a disciplinary body of a component medical society. Under no circumstances, however, shall the Committee on Peer Review exercise any disciplinary function nor shall it be empowered to alter the status or standing of any member. The committee shall be empowered to prescribe its rules of operation which shall not be in conflict with the policies or By-Laws of the Association. The committee shall also encourage and assist component medical societies in forming Committees on Peer Review at the local level.

Section 4. Committee on Publications. The Committee on Publications shall consist of six members. These shall consist of the Editor, the two Associate Editors, and three others, the three latter being appointed by the Board of Trustees for terms of three years which are so arranged to provide for appointment of one such member annually. The chairman of the committee shall be designated by the Board. The

committee shall implement instructions and policies of the Board of Trustees relating to the official JOURNAL of the Association. Additionally, the committee shall study and recommend to the Board policy proposals relating to organization and production of the JOURNAL, reporting annually its deliberations.

Section 5. Committee on Medicine and Religion. The Committee on Medicine and Religion shall consist of six members appointed for terms of three years each and so arranged to provide for appointment of two members annually. The committee shall be responsible for formulating a program in the field of medicine and religion and for carrying out such assignments as may be made in this connection by the Board of Trustees.

Section 6. Committee on Long-Range Planning. The Committee on Long-Range Planning shall consist of five members appointed for terms of five years each and so arranged to provide for appointment of one member annually. This committee shall receive charges from the Board of Trustees and shall assess developments and requirements in fields of association activity, making recommendations for courses of action to achieve maximum possible effectiveness in all fields of association activity.

Chapter XI RULES AND CONDUCT

The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

Chapter XII COMPONENT SOCIETIES

Section 1. Component Societies. All component societies now in affiliation with this Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Board of Trustees and approval by the House of Delegates, receive a charter from and become a component part of this Association. The Board of Trustees and House of Delegates, on recommendation by the Judicial Council, shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and By-Laws.

Section 2. Number of Societies. Only one component medical society shall be chartered in any county but nothing in this section shall be construed as to prohibit unofficial organization of medical clubs or other county level groups of physicians whose purpose it is to further and advance scientific medicine and postgraduate medical education.

Section 3. Members of Societies. Each component society shall judge the qualifications of its own members, but as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who is qualified under Chapter I, Section 1, of these By-Laws shall be eligible for election to membership. Before a charter is issued to any component society, full and ample opportunity shall be given to every such physician in the county to become a member.

Section 4. Right of Appeal. Any physician who may feel aggrieved by the action of the society of his county or District in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Judicial Council, which, upon a majority vote, may permit him to petition for membership in an adjacent society.

Section 5. Evidence of Appeals. In hearing appeals, the Judicial Council may admit oral or written evidence, as in its judgment will best and most fairly present the facts, but

in case of every appeal, efforts at a conciliation and compromise shall precede all such hearings.

Section 6. Area Jurisdiction. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Section 7. Professional Authority. Each component society shall have general direction of the affairs of the profession in its jurisdiction and shall constantly use its influence to the moral and professional betterment of its physicians, to the end that the membership shall embrace every qualified physician in its jurisdiction.

Section 8. Meetings. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall especially be encouraged to do postgraduate work, and to give the society first benefit of such labors. Official positions and other preferences shall be unstintingly given to such members.

Section 9. Delegates. Each county shall be entitled to representation in the House of Delegates of this Association, one delegate for each fifty members or fraction thereof. Delegates shall be elected for terms of not less than two years and societies shall report such elections to the Executive Secretary of the Association in no event later than thirty days before the annual session.

Section 10. Duties of Component Society Secretaries. The secretary of each component medical society shall perform such duties as are usual and customary to his office. He shall maintain the official roll of membership for his society, shall

collect dues and assessments, and shall make official reports as elsewhere prescribed in these By-Laws to the Association, transmitting dues in behalf of component society members. He shall conduct the official correspondence of his component medical society.

Chapter XIII FISCAL YEAR

The fiscal year of the Association and its component county societies shall begin January 1 each year and end on December 31 following, but membership in the state Association shall not lapse until April 1 of that year.

Chapter XIV AMENDMENTS

These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, after the amendment has laid upon the table for one day.

Chapter XV REPEALING AUTHORITY

Upon adoption of these By-Laws, all previous By-Laws, motions of record, mandates, policies, rules and regulations in conflict therewith are hereby repealed, except that officers elected to serve in the Association and its component societies shall continue their incumbency until the completion of their previously prescribed terms and their successors elected under the current By-Laws.

PREVENTING PROFESSIONAL ASSAULT

Congressman Paul Simon (D-24) of Illinois gave the following four ways to prevent assaults on your profession at the AMA's National Leadership Conference:

1. The public must perceive that you are not abusing the privileges of your profession.
2. The public must perceive that you care about the public, not just your own economic interests.
3. You must strive for a higher ethic than the public imposes upon you.
4. You must look at the long-range picture and become a leader in the progress of your profession. Don't live from crisis to crisis, but think of the long-range goal of improving the society as a whole.

—*Tennessee Medical Journal*



The President Speaking

AMA Convention

JAMES O. GILMORE, M.D.
Oxford, Mississippi

WE RECENTLY attended the AMA meeting in San Francisco. The meeting, weather and food were fine, but I cannot say as much for Joseph Califano's remarks to the House of Delegates. We were told by Mr. Califano that we *would* have a national health insurance program during Mr. Carter's administration. He also stated that it would be nice if the doctors went along with the program, but whether doctors cooperated or not, there *would* be a national health insurance program. I, personally, still have the foolish idea that only a physician can practice medicine.

Mr. Califano also stated that the cost containment program for hospitals is in the mill now and that physicians' fees are the next item on the agenda. He made several references to affluent physicians. I understand that Mr. Califano made in the neighborhood of \$550,000 last year in private law practice and to me, that's a pretty nice neighborhood.

The Mississippi resolution to equalize Medicare fees was again referred to the Council on Medical Services. There were four other similar resolutions and they were also referred to the council. When this issue first came up, we stood alone.

The House of Delegates took the position that Laetrile is not a drug and therefore has no use in the treatment of cancer. One delegate from California suggested that the best solution to the Laetrile controversy was to make it available across the counter at the local drug stores. In addition, the House of Delegates felt that saccharin needed further study as far as any causal relationship to cancer of the bladder is concerned.

We enjoyed visiting with officers and delegates from other states and found that we all share similar problems. The best solution seems to be in unity and organization.

In closing, I thought you might be interested in a recent report concerning the Mississippi Physician Census of 1975. This was conducted by the State Board of Health and revealed the following data:

- 1) There were 2,144 physicians in active practice.
- 2) Of these physicians, 1,456 were self-employed, 163 were "non-governmental employed," and 491 were employed by local, state or federal government.
- 3) Median age of all physicians in active practice was 43.8 years. Median hours of work per week was 60.6 hrs.
- 4) 503 of the physicians in active practice were in general practice and 459 were in surgery.
- 5) There were 49 black physicians in active practice.

In closing, I would again urge each of you to participate in and support your medical societies at all levels. Unity and organization is our prime weapon against the present problems faced by physicians. ★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XVIII, NUMBER 8

AUGUST 1977

The Age of Retirement

Age 65 has been generally adopted as the standard age of retirement. All of us know some persons who should retire at age 50 and others who are still going strong in their 70's. A physician in solo practice may retire when he chooses or continue to work as long as he is physically and mentally capable of caring for his patients. However, most hospital staff rules require retirement of heads of departments at age 65 and mandatory retirement from the active staff at age 70.

It would be a most difficult chore to suddenly tell "the grand old man" who has served so well for many years that he can no longer admit patients to the hospital; but if these rules are made well in advance, it is expected and usually accepted in good grace.

The elderly physician may be the last to realize that he is no longer as sharp mentally or physically as he used to be and that the newer advances in medicine have left him behind. Being in moderately good health, he may feel that retirement is a waste of his vast knowledge and experience and becomes depressed at the thought of medicine passing him by. Yet, secretly he is pleased to have an excuse to retire with dignity and begin the leisurely life he has so justly earned.

After all, the old must give way to the young so that medical progress can continue.

GEORGE H. MARTIN, M.D.
Associate Editor

Medico-Legal Brief

Maximum Allowable Cost Regulations Upheld by Federal Trial Court

Regulations issued by HEW commonly referred to as Maximum Allowable Cost Regulations are valid, a federal trial court in Illinois ruled. The MAC regulations established the procedure for setting drug

reimbursement amounts under Medicare and Medicaid programs.

A Pharmaceutical Reimbursement Board composed of HEW employees was created to identify "multiple-source drugs" and to determine the reimbursement prices. The Board is advised by a committee of experts from pharmacy, pharmacology, medicine, marketing, public health, and consumers.

The Board determines the lowest unit price at which a multiple source drug is widely and consistently available. A MAC is proposed and subject to public comment before being finalized. The regulations undertake to reduce the cost of prescription drugs paid for by Medicare and Medicaid.

Contesting the validity of the regulations, the American Medical Association, the Pharmaceutical Manufacturers Association, and five physicians filed suit against HEW. In a 74-page opinion, the federal trial court granted the government's motion for dismissal of the suit.

The court said that the MAC regulations satisfy a statutory requirement for establishing a method of determining what costs are unnecessary to the efficient delivery of drugs. The MAC regulations do not violate the Social Security Act's reimbursement standards, the court said.

In addition, the court said the MAC regulations do not constitute unlawful federal control over the practice of medicine and do not establish regulatory procedures that violate Administrative Procedure Act.

On the issue of drug quality, the court said that FDA programs, despite some inadequacies, were functioning enough to assure the quality of drugs. Bioinequivalence was neither a major problem nor an insurmountable obstacle to the MAC program, the court said.

The court supported the government's position on all issues raised in the suit.—*American Medical Association v. Mathews*, Docket No. 75 C 2512 (D.C., Ill., March 7, 1977)

PERSONALS

RICHARD COLLIER has set up his offices for the practice of general surgery in the Bramlett Clinic Building in Oxford.

ROBERT M. COOK announces the removal of his office from Lumberton to the Medical Plaza, Suite 204, Hattiesburg, in association with Drs. Austin, Carroll and Hughes for the practice of family medicine.

W. MELVIN FLOWERS, JR. of Jackson and UMC was co-author of a paper he presented at the 24th annual meeting of the Society of Nuclear Medicine in Chicago in June.

KARL W. HATTEN of Vicksburg has been elected chairman of the medical advisory committee to the Kidney Foundation of Mississippi.

MITT HOBBS has associated with THOMAS RANDLE of Oxford for the practice of internal medicine.

BRAXTER P. IRBY, JR., has associated with RICHARD FULLER in his clinic on Biglane Drive in Brookhaven for the practice of internal medicine.

MYRON W. LOCKEY of Jackson and UMC participated in a symposium on "current therapy for malignancy of the oral cavity" in Bethesda, MD.

RONALD R. LUBRITZ of Hattiesburg has co-authored a textbook for the American Academy of Dermatology in conjunction with Dr. D. Torre of Cornell University, New York. The text's title is "Cutaneous Cryosurgery: Treatment of Non-Malignant Lesions."

LYNDA LEE MITCHELL of Moss Point has been selected Outstanding Young Woman of Moss Point by the Moss Point Jaycettes. She is clinic physician for the Jackson County Health Department and Youth Shelter.

R. P. MORRIS of Moss Point was honored for his years of service to the citizens of Jackson County by a celebrity roast and banquet held at the Elks Club and sponsored by the Astro Social Club.

ROBERT E. SCHWARTZ of Hattiesburg was honored recently by the South Mississippi Medical Society for his 50 years of medical practice. He received a certificate and gold "50 year" lapel pin from the Mississippi State Medical Association.

BERNARD L. SHIPP of Corinth attended the intra-ocular lens and microsurgery of the eye seminar held

at the Tulane University Medical Center in New Orleans.

ANTONE TANNEHILL of Tupelo was named physician of the year at the North Mississippi Medical Center's annual Employee Recognition Dinner.

R. FASER TRIPLETT of Jackson has been elected to the board of directors of Jackson Savings and Loan Association.

THURSTON WILKES has opened his practice of urology in the Bramlett Clinic Building in Oxford.

W. D. YOUNG announces the opening of his surgery practice at Wayne General Hospital in Waynesboro.

POSTGRADUATE CALENDAR

Sept. 17, 1977

COMMON HAND INJURIES

Mississippi Methodist Rehabilitation Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery, the University Medical Center Division of Continuing Health Professional Education, and the Mississippi Methodist Rehabilitation Center.

Coordinators: Michael E. Jabaley, M.D., professor of surgery and chief of the division of plastic surgery, University of Mississippi School of Medicine and Charles W. Emerson, Jr., M.D., chief, hand and upper extremity service, Mississippi Methodist Rehabilitation Center.

This half-day course is designed for the family practitioner and emergency room physician. Credit: 4 contact hours, 14 CEU, Category 1, AMA; AAFP.

FUTURE CALENDAR

Oct. 17-21, 1977

FAMILY PRACTICE REVIEW

Holiday Inn Medical Center, Jackson

Nov. 10-11, 1977

CARDIOVASCULAR REVIEW—1977

University Medical Center, Jackson

Mar. 9-11, 1978

SURGICAL FORUM V

Holiday Inn Downtown, Jackson

Mar. 30-Apr. 1, 1978

GASTROENTEROLOGY UPDATE
Ramada Inn Coliseum, Jackson

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

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IN CONCLUSION

Statistics compiled by the AMA from 47 states show that disciplinary actions against physicians tripled in the past five years. In 15 states which have enacted legislation making reporting of professional malpractice mandatory, the number of investigations initiated by the state medical disciplinary bodies has increased six-fold. Much of this increase can be attributed to the immunity provisions for those required to report under these laws. Immunity for such reporting enables physicians to do so without fear of civil liability.

The top killer diseases of the 1950s either have been eliminated or are in decline, according to HEW National Center for Health Statistics. In particular, the death rate among men aged 25-44 has decreased over the last 25 years. Tuberculosis has been virtually eliminated, and rates of death from heart disease and some forms of cancer have declined substantially. Death rate from accidents fluctuates and more Americans are committing suicide today. A "startling" increase in lung cancer death rates has occurred since 1950, including higher rates for women.

The AMA is continuing its campaign to stem television violence. The Board of Trustees has voted financial support for three projects totaling \$147,329. Partial support went to the Violence Index and Profile of the University of Pennsylvania which analyzes and reports on network television trends and viewer conceptions of social reality; the National Parent-Teachers Association for the development of a public report outlining various components of PTA's TV violence project; and to the National Citizens Committee for Broadcasting for a six-week rating study.

Seventy-eight per cent of "preventable" complications or deaths that resulted from medical operations in seven states involved the surgeon, according to an American College of Surgeons study submitted to a House Investigations Committee. Remaining 22 per cent were blamed on the hospital where surgery was performed, patient or community. Technique was the most common factor responsible; postoperative care was far behind in second place and following were inadequate diagnosis, poor judgement, and bad preoperative care.

Emergency room care is expensive, especially when patients use ERs as a convenience rather than for true emergency care. To help subscribers to spend health care dollars more wisely, Blue Shield plans in Michigan and Central New York issued emergency room care guidelines. They redefined "medical emergency" to exclude routine medical care. To use the ER, a subscriber should ask himself if the medical problem occurred unexpectedly, if it is life threatening, and if it is serious enough that MD's services are needed quickly to avoid serious health consequences.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psycho-

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tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

ship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

THE ANXIETY-SPECIFIC

Since its discovery in the research laboratories at Roche, Librium® has been the object of ongoing pharmacologic and clinical investigation.

The published record on Librium is enormous. So large, in fact, we put it into a computer literature retrieval system to make it more accessible in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® 
chlordiazepoxide HCl / Roche



*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

September 1977

BALCONY

Journal of the
State Medical
Association

Mississippi



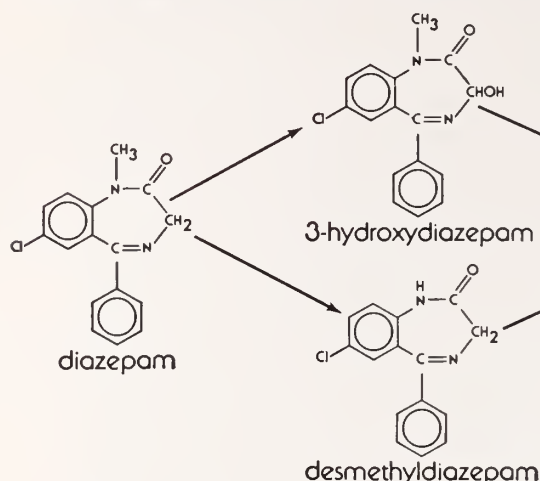
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**Surgical Management
of Large Breasts**

**Management of Pain
of Malignancy**

Odontoid Fracture

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) ^{IV}

2-mg, 5-mg, 10-mg scored tablets
a prudent choice in psychic
tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due

to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated:

Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

There are any number of excellent reasons why you need extra money when hospitalized.

And that's all the more reason why you should enroll in the

MSMA Sponsored Hospital Money Plan®

- Benefits of up to \$100 per day for hospitalization due to a covered accident or sickness.
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- Benefits payable directly to you (unless assigned) in addition to any other insurance you may have.

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With hospital costs at an all time high, there is an urgent need for extra protection — beyond your basic hospital policy. And you can get this vital protection regardless of your past or present health history! Even if you've been refused coverage elsewhere! Because acceptance is guaranteed for you, your spouse, and all eligible, unmarried dependent children under this officially-sponsored Mississippi State Medical Association's HOSPITAL MONEY PLAN.*

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Best of all, this high benefit, low-cost supplemental protection can be **renewable to MSMA members, regardless of age.**

Watch for details, including information on costs, exclusions, any reductions and terms under which coverage may be continued in force in the mail. If you do not receive your mailing, you can obtain full information by returning the coupon below to your MSMA Insurance Administrator.

Mississippi State Medical Association-sponsored Insurance Programs are underwritten by:
Continental Casualty Company,
one of the CNA insurance companies
Chicago, Illinois



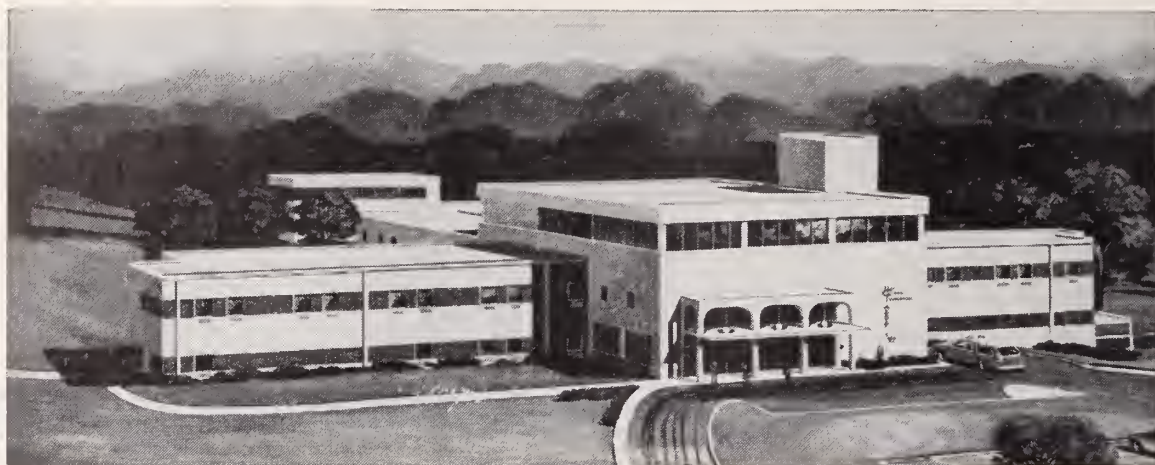
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Address _____

City _____ State _____ Zip _____

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For Intensive Treatment of Psychiatric Disorders

This 101-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

ADMINISTRATOR: Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South

PHONE: 205-836-7201

Birmingham, Alabama 35212

Volume XVIII

Number 9

September 1977



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (Publication No. 284800) is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$15.00 per annum; \$2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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ISSN 0026-6396

63rd ACS Clinical Congress Is Set for Dallas

The 63rd annual Clinical Congress of the American College of Surgeons will be held in Dallas, Oct. 17-21, 1977. The college anticipates registration of 10,000 physicians for the congress, with a total attendance exceeding 18,000, including guests and members of other medical professions.

Co-headquarters for the scientific meeting will be the Fairmont Hotel and the Dallas Hilton. Main registration will take place, and exhibits will be displayed, at the *Dallas Convention Center*, with advance registration desks in several hotels.

The program will include: 18 postgraduate courses on a wide range of subjects; 270 research-in-progress reports by young investigators, known as the Forum on Fundamental Surgical Problems; over 50 panel discussions and symposia on general surgery and other surgical specialties; film programs, including the popular series, "Spectacular Problems in Surgery"; a summary of "What's New in Surgery?"; major addresses by prominent guest lecturers, including lectures by Robert S. McNamara, president of the World Bank, and Theodore Cooper, immediate past Assistant Secretary for Health, Department of HEW; presentation of the college's Distinguished Service Award; and awarding of Fellowship to more than 1500 surgeons in convocation ceremonies on Thursday, Oct. 20.

Registration at the congress is free for Fellows of the college whose dues are paid to December 1976; Initiates; participants in the Candidate Group; and surgical residents. Non-Fellows pay \$140. Non-Fellow physicians in the federal service full time pay \$100. Everyone who enrolls in one of the 18 postgraduate courses, including those who register free for the congress, must pay the fee for the courses selected.

The continuing education programs of the college are accredited by the American Medical Association. Each hour of the program is equivalent to one hour of Category I credit toward the AMA Physician's Recognition Award.

Memphis Perinatal Conference Planned

The ninth Memphis conference on the mother, fetus, and newborn is scheduled for Sept. 29-30 at the Holiday Inn Rivermont.

Tuition fees are \$60.00 for physicians and \$20.00 for other health professionals.

For information or reservations, write Division of Continuing Education, UTCHS, 800 Madison Avenue, Memphis, TN 38163.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)

ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 $\mu\text{g/ml}$) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

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**When you're good
people recognize you.**

Highly effective
Single-dose convenience
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Economical
Pleasant tasting

Antiminth[®]
(pyrantel pamoate)

equivalent to 50 mg pyrantel/ml
ORAL SUSPENSION



a drug of choice in
pinworm infections

Please see brief summary of prescribing information on facing page.

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BREATHING WITH COMFORT.

Choledyl — a highly soluble, true salt of theophylline — rapidly relaxes bronchospasm to promote easier breathing. And, gastric discomfort is minimal.

Because Choledyl is more stable...more rapidly absorbed from the G.I. tract than aminophylline.

Available in both tablets and elixir for patients with obstructive lung disease.

Choledyl® (oxtriphylline) Tablets and Elixir CAUTION: Federal law prohibits dispensing without prescription. Each partially enteric coated tablet contains 200 mg or 100 mg oxtriphylline. Each teaspoonful of the elixir contains 100 mg oxtriphylline; alcohol 20%. **Indications.** Choledyl (oxtriphylline) is indicated for relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema. **Warning.** Use in pregnancy—animal studies revealed no evidence of teratogenic potential. Safety in human pregnancy has not been established; use during lactation or in patients who are or who may become pregnant requires that the potential benefits of the drug be weighed against its possible hazards to the mother and child. **Precautions.** Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children. **Adverse Reactions.** Gastric distress and, occasionally, palpitation and CNS stimulation have been reported. **Dosage.** Average adult dosage: Tablets—200 mg, 4 times a day; Elixir—two teaspoonfuls, 4 times a day. **Supplied.** 200 mg yellow, partially enteric coated tablets in bottles of 100 (N 0047-0211-51) and 1000 (N 0047-0211-60); Unit Dose—200 mg tablets (N 0047-0211-11); 100 mg red, partially enteric coated tablets in bottles of 100 (N 0047-0210-51). Elixir—bottles of 16 fl oz (1 pint) 474 ml (N 0047-0215-16). **Toxicity.** Oxtriphylline, aminophylline and caffeine appear to be more toxic to newborn than to adult rats. No teratogenic effects have been seen. Full information is available on request.

WC
CH-GP-51-4/C

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Division: Warner-Lambert Company
Morris Plains, N.J. 07950

CHOLEDYL®

(OXTRIPHYLLINE)

SINGLE-ENTITY
BRONCHODILATION
MINIMAL GASTRIC DISCOMFORT

Interstate Scientific Assembly Is Scheduled

The 62nd Annual International Scientific Assembly of Interstate Postgraduate Medical Association will be held at the Diplomat Hotel in Hollywood, FL, on Oct. 31-Nov. 1-3, 1977. This program is designed for primary care physicians practicing in the U. S. and Canada. It has been planned cooperatively with the Florida Academy of Family Physicians, the University of Miami and the University of Florida-Gainesville and provides 26 hours of credit for American Academy of Family Physicians members and toward the AMA Physician's Recognition Award.

The program consists of lectures, informal group discussions, "live" closed-circuit TV and medical movies on a variety of topics with emphasis on infectious diseases, endocrinology, cardiovascular, nephrology, nutrition and rheumatology. Guest lecturers include: Dr. Irvine H. Page of the Cleveland Clinic Foundation on "Science and Intuition in Medical Practice"; Dr. Ray Gifford of the Cleveland Clinic Foundation on "Hypertension Update"; Dr. Robert W. Kistner of Harvard on "Major Gynecologic Problems Associated with Oral Contraceptives"; Dr. Walter Spitzer of McGill University,

Montreal, Quebec, on "A New Look at the Value of the Periodic Health Examination"; Dr. Joseph Hollander of the University of Pennsylvania on "Diagnosis of Painful Joints." In addition there will be other lecturers from the University of Florida-Gainesville and the University of Miami. The Thursday session will be devoted to "Medical-Surgical Update."

The assembly is open to any licensed physician in the U. S. and Canada for a fee of \$75.00 in advance or \$100.00 at the meeting. Those interested in the meeting and hotel forms should write to: Alton Ochsner, M.D., Program Chairman, Interstate Postgraduate Medical Association, P. O. Box 1109, Madison, WI 53701.

Southern Perinatal Association Meets

The fifth annual meeting of the Southern Perinatal Association is set for Sept. 25-28 at the Hyatt House in Winston-Salem, NC.

Fees are \$25.00 for regular members, \$10.00 for associate members and \$30.00 for nonmembers.

For information contact Ms. Sandra Kubarych, R.N., University of Louisville School of Medicine, 323 East Chestnut Street, Louisville, KY 40202.

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- the chance to discuss practice opportunities in 60 communities from the coast to the mountains
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Box 12200
Raleigh, N. C. 27605

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City State Zip _____
Date Available _____
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☐ Internal Medicine
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☐ Pediatrics
☐ Emergency Room
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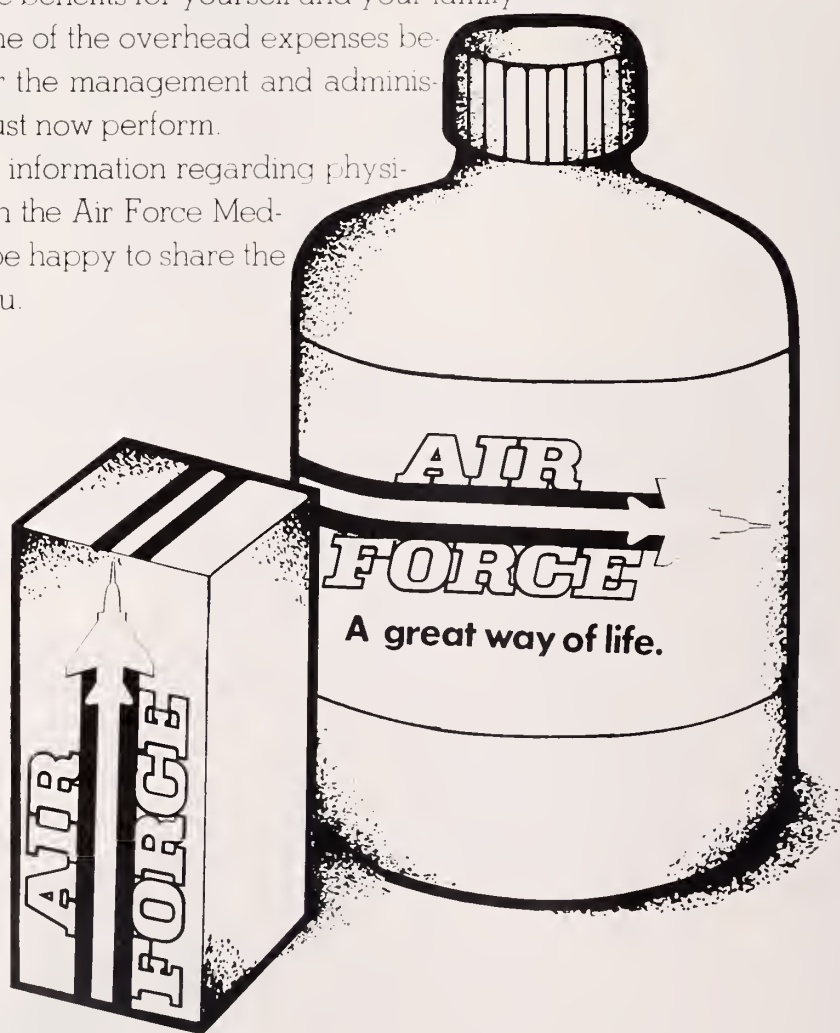
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NEWSLETTER

September 1977

Dear Doctor:

The Mississippi State Board of Health has adopted the following statement concerning Laetrile: "Due to the lack of scientific proof of the medical validity of the drug Laetrile in treating cancer patients, this Board cautions Mississippi physicians against prescribing or recommending the use of this drug except under approved clinical trial as may be outlined by the National Institutes of Health."

At its August 18-19, 1977, meeting the MSMA Board of Trustees adopted the following statement concerning Laetrile: "It is the position of the Mississippi State Medical Association that Laetrile is a substance that has no proven value as a drug."

In a report on Arlene Hershman's "The Race to Cut Medical Costs," Dun's Review states: "If the American people can't put a halter on wildly escalating medical costs, it won't be for lack of trying. The federal government has spent \$11 million since 1972 just for studies on why medical costs are soaring and what to do about them" (Reprinted from Mississippi Hospital Association Newsletter).

The federal Drug Enforcement Agency has listed the 24 drugs most often stolen from pharmacies: Amytal, Benzedrine, Darvon, Demerol, Desoxyn, Dexamyl, Dexedrine, Dilaudid, Empirin with codeine, Eskatrol, Fiorinal with codeine, Librium, morphine, Miltown, Nembutal, Obetrol, Percodan, Placidyl, Preludin, Quaalude, Ritalin, Seconal, Tuinal, and Valium.

The National Congress of County Medical Societies, the Private Medical Care Foundation and the medical journal "Private Practice" will conduct a "Seminar on Survival of the Private Medical Care System" in Jackson on October 13 at the Medical Center Holiday Inn beginning at 8:00 p.m. Physicians, medical students and their spouses are invited. There is no charge for admission.

A new Audio Medical Abstract being released by Modern Medicine publications focuses on the primary physician and is well balanced and interesting, according to the editor of the Journal MSMA. The cost is comparable to other similar services and a free introductory tape will be sent to any physician who writes: Medical Monitor, 4015 West 65th Street, Minneapolis, MN 55435.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

*helping you change things
for the better*

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**it's
the real
thing**



70-37

**Mississippi Council of
Coca-Cola Bottlers**

Clinical Perinatal Medicine Symposium Scheduled

The Alton Ochsner Medical Foundation presents the second annual symposium on clinical perinatal medicine Oct. 7-8 at Ochsner Foundation Hospital in New Orleans.

The symposium is open to practicing physicians, residents, nurses and respiratory therapists. Fee is \$30.00 for physicians and \$15.00 for others.

This course has been approved for 7¼ credit hours by the AMA (Category 1) and the American Academy of Family Physicians (elective hours).

For more information, write Division of Continuing Education, Ochsner Foundation, 1516 Jefferson Highway, New Orleans, LA 70121.

HEW Issues Abortion Policy

Dr. George A. Reich, Regional Health Administrator for the Department of H.E.W., has recently clarified federal policy on payments for abortions.

In an Aug. 8 letter to MSMA, Dr. Reich states that "the Department (H.E.W.) will provide federal financial participation in the cost of abortions only where the attending physician, on the basis of his or her professional judgement, has certified that the abortion is necessary because the life of the mother would be endangered if the fetus were carried to term."

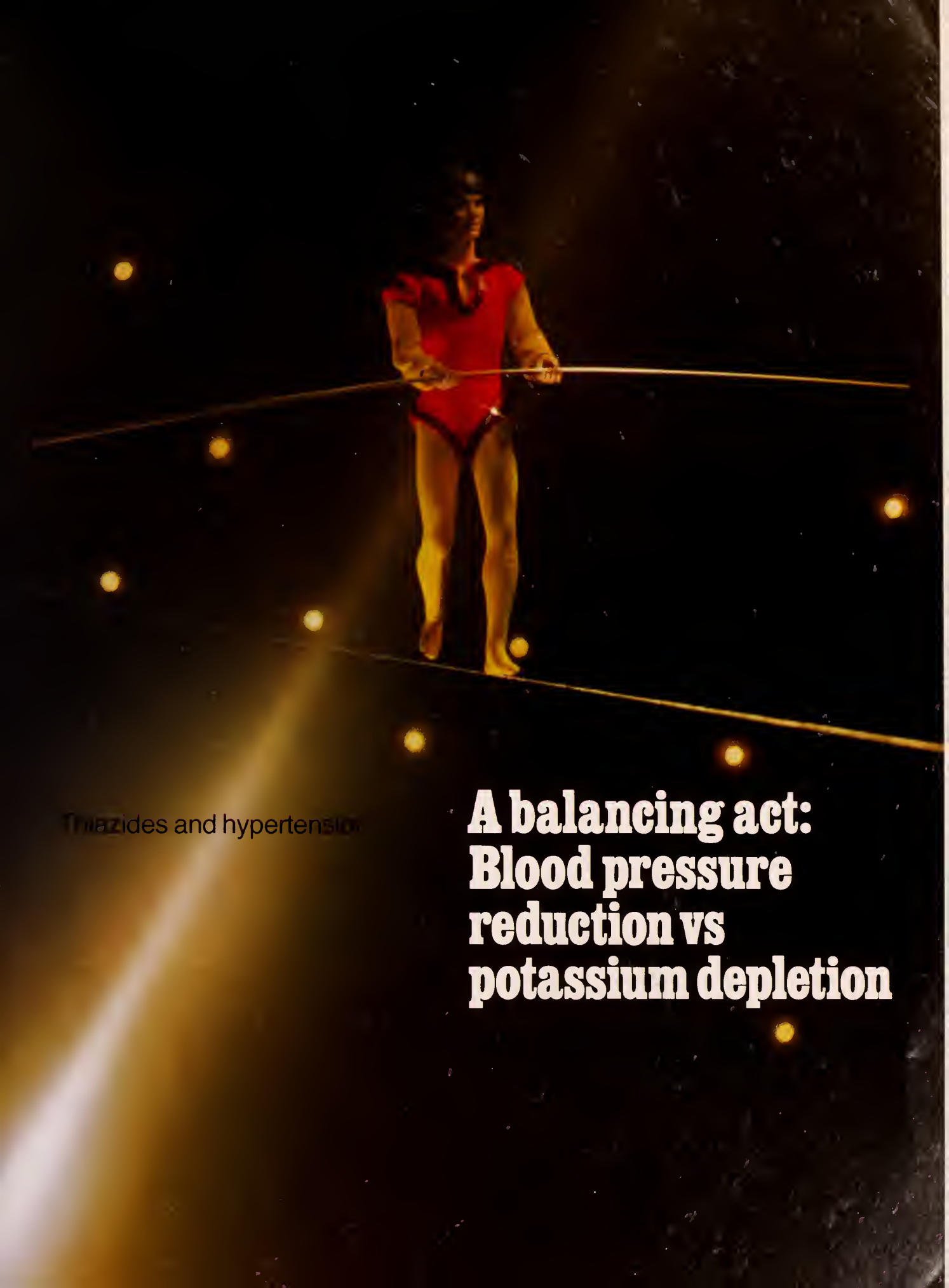
Payment will continue to be available for medical procedures to terminate an ectopic pregnancy and for the treatment of rape and incest victims before the fact of pregnancy is established.

Cost Saving Initiatives Draw Fire

Two cost saving "initiatives" suggested by new Health Care Financing Director, Robert A. Derzon, in an "idea paper" prepared for H.E.W. Secretary Califano have drawn the wrath of the Catholic Hospital Association.

Derzon suggested "living wills" and abortion legislation by the states as cost cutting mechanisms and CHA says the two ideas are "despicable and inhuman."

The "living will" would allow a person to declare in advance what he would wish done if he should reach a moribund condition and according to Derzon would result in "enormous" cost savings since "over one-fifth of Medicare expenditures are for persons in their last years of life."



Thiazides and hypertension

**A balancing act:
Blood pressure
reduction vs
potassium depletion**

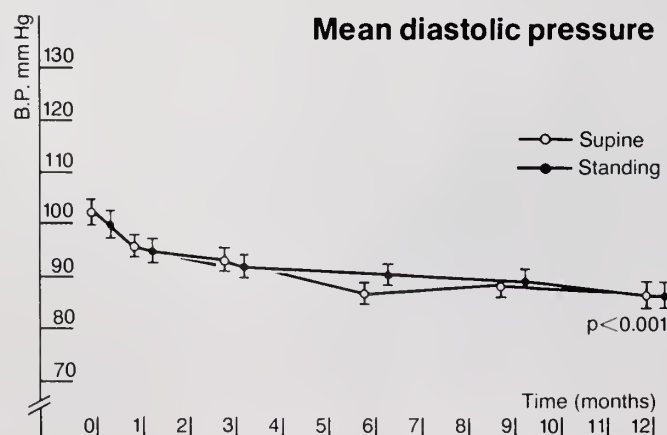
From a 1-year study of 18 patients
with mild uncomplicated
hypertension published in The Lancet*

Once a day

Naturetin®

Bendro-
flumethiazide
Tablets N.E.

Diastolic blood pressure down 12-15%



"The mean pretreatment blood pressure was 170/103 mmHg (supine) and 166/100 mmHg (standing). Diastolic pressure continued to fall over the first 6 months and then there was no further change up to 1 year...The mean blood pressure at 12 months was 153/88 mmHg (supine) and 142/88 mmHg (standing)."

"The patients were receiving a single daily dose of 10 mg bendrofluazide [bendroflumethiazide]...there were no apparent side effects from the medication."

* Wilkinson PR et al: The Lancet 1:759-762, 1975.



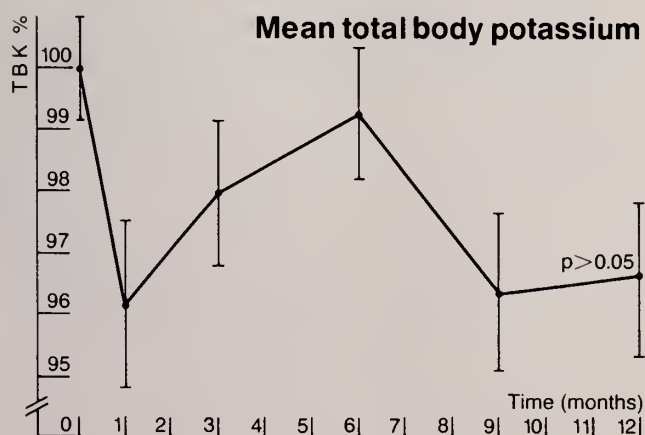
Once a day

Naturetin®

Bendro-
flumethiazide
Tablets N.F.

2.5, 5 and 10 mg

Potassium stabilized at 96% mean TBK



"The amount of potassium loss during the period of study did not seem to be clinically significant."

"A serum potassium of less than 3.5mmol per litre is often taken as the value below which potassium supplements should be given...At an arbitrary lower value for serum potassium of 3.0mmol per litre, few patients, our data suggest, would need potassium supplements. Our findings with TBK support this view..."

See next page for full prescribing information.

Once a day **Naturetin**[®] **Bendroflumethiazide** **Tablets N.F.**

NATURETIN[®]-2.5

NATURETIN[®]-5

NATURETIN[®]-10

Bendroflumethiazide Tablets N.F.

DESCRIPTION

Naturetin (Bendroflumethiazide Tablets N.F.) is a benzothiadiazine derivative containing a benzyl and a trifluoromethyl group. It is a potent oral diuretic and antihypertensive agent available as compressed tablets providing 2.5, 5.0, or 10 mg.

bendroflumethiazide.

ACTIONS

The mechanism of action results in an interference with the renal tubular mechanism of electrolyte reabsorption. At maximal therapeutic dosage all thiazides are approximately equal in their diuretic potency. The mechanism whereby thiazides function in the control of hypertension is unknown.

INDICATIONS

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated as adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis and corticosteroid and estrogen therapy.

Bendroflumethiazide has also been found useful in edema due to various forms of renal dysfunction such as: nephrotic syndrome, acute glomerulonephritis, and chronic renal failure.

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated in the management of hypertension either as the sole therapeutic agent or to enhance the effectiveness of other antihypertensive drugs in the more severe forms of hypertension.

Usage in Pregnancy. The routine use of diuretics in an otherwise healthy woman is inappropriate and exposes mother and fetus to unnecessary hazard. Diuretics do not prevent development of toxemia of pregnancy, and there is no satisfactory evidence that they are useful in the treatment of developed toxemia.

Edema during pregnancy may arise from pathological causes or from the physiologic and mechanical consequences of pregnancy. Thiazides are indicated in pregnancy when edema is due to pathologic causes, just as they are in the absence of pregnancy (see WARNINGS). Dependent edema in pregnancy, resulting from restriction of venous return by the expanded uterus, is properly treated through elevation of the lower extremities and use of support hose; use of diuretics to lower intravascular volume in this case is illogical and unnecessary. There is hypervolemia during normal pregnancy which is harmful to neither the fetus nor the mother (in the absence of cardiovascular disease), but which is associated with edema, including generalized edema, in the majority of pregnant women. If this edema produces discomfort, increased recumbency will often provide relief. In rare instances, this edema may cause extreme discomfort which is not relieved by rest. In these cases, a short course of diuretics may provide relief and may be appropriate.

CONTRAINDICATIONS

Bendroflumethiazide is contraindicated in anuria.

It is also contraindicated in patients who have previously demonstrated hypersensitivity to it or other sulfonamide-derived drugs.

WARNINGS

Bendroflumethiazide should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may be additive or may potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers. Thiazides appear in breast milk. If use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS

Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: dryness of the mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes mellitus may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS

Gastrointestinal System: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), and pancreatitis.

Central Nervous System: dizziness, vertigo, paresthesia, headache, and xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, and aplastic anemia.

Dermatologic-Hypersensitivity: purpura, photosensitivity, rash, urticaria, and necrotizing angitis (vasculitis, cutaneous vasculitis).

Cardiovascular: orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics.

Other: hyperglycemia, glycosuria, occasional metabolic acidosis in diabetic patients, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, and restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSAGE AND ADMINISTRATION

Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

Diuretic: The usual dose is 5 mg. once daily, preferably given in the morning. To initiate therapy, doses up to 20 mg. may be given once daily or divided into two doses. A single daily dose of 2.5 to 5 mg. should suffice for maintenance.

Alternatively, intermittent therapy may be advantageous in many patients. By administering the preparation every other day or on a three to five day per week schedule, electrolyte imbalance is less likely to occur; however, the possibility still exists.

In general, the lowest dosage that achieves the therapeutic response should be employed.

Antihypertensive: The suggested initial dosage is 5 to 20 mg. daily. Maintenance dosage may range from 2.5 to 15 mg. per day, depending on the individual response of the patient. When the diuretic is used with other antihypertensive agents, lower maintenance doses for each drug are usually sufficient.

STORAGE

Store at room temperature; avoid excessive heat.

HOW SUPPLIED

2.5 mg. tablets in bottles of 100, 5 mg. tablets (scored) in bottles of 100 and 1000, and 10 mg. tablets (scored) in bottles of 100.

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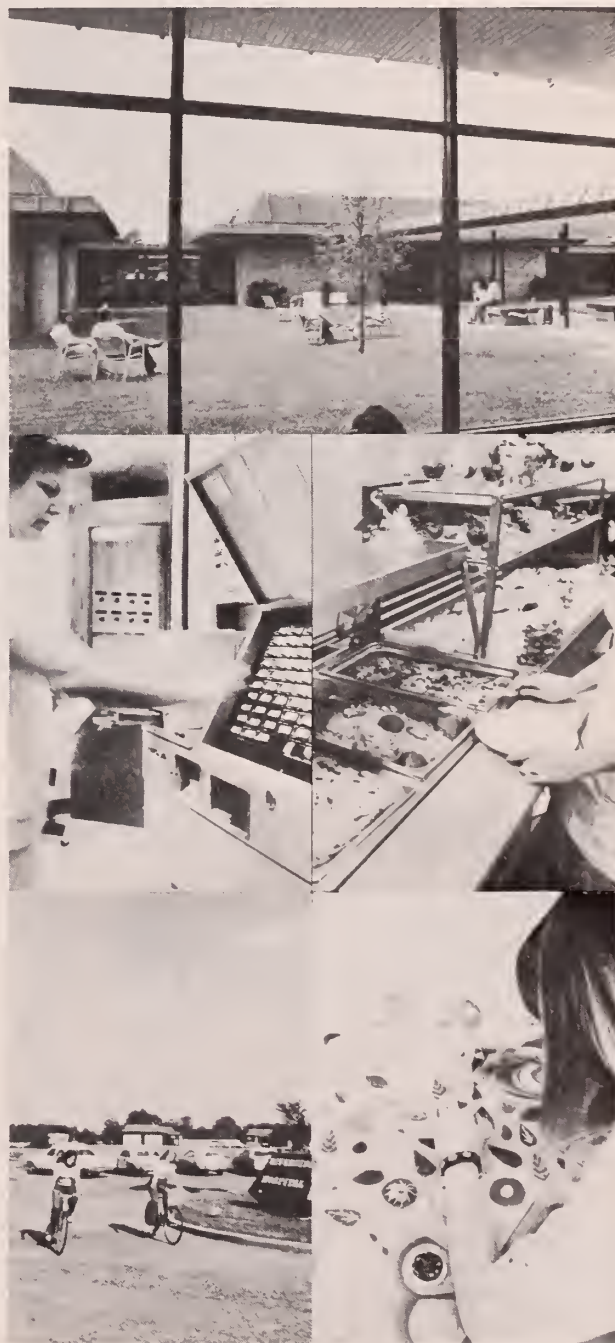
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For additional information contact: John R. Reedy,
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the compatible vasodilator

TABLETS, 20 mg.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose, Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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DATELINE

High Blood Pressure Report Is Available

Bethesda, MD - Representatives of major medical associations have reached agreement in the Report of the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure. The report offers a simple, economic approach to diagnosis and treatment of hypertension and patient education. Available in August, the report may be ordered from the High Blood Pressure Information Center, 120-80 National Institutes of Health, Bethesda, MD 20014.

AMA Urges Physician Sponsored PSROs

Chicago, IL - Physicians in undesignated Professional Standard Review Organization areas were urged by the American Medical Association House of Delegates recently to review decisions on establishing physician-sponsored PSROs. After January 1, 1978, the Department of Health, Education, and Welfare is authorized to name qualified alternative organizations as PSROs in areas where one is not sponsored by physicians.

Many Now Have Hospital Insurance

Washington, D.C. - Nearly 178 million persons in the U.S. had private hospitalization insurance at the beginning of 1976, according to a recent report of the Health Insurance Institute. This represents an increase of about 5 million persons in one year. The report also states that about 147 million persons have private catastrophic coverage, an increase of about 2 million from the previous year. Health insurance premiums totalled \$38.8 billion in 1975, while benefit payments were \$32 billion.

Medicaid Recognizes Nurse Practitioners

Jackson, MS - The Mississippi Medicaid Commission is seeking a demonstration grant to test the feasibility, acceptability and effectiveness of reimbursing clinics in Mississippi for services rendered by nurse practitioners. The Mississippi State Medical Association and the Mississippi Nurses Association support the physician/expanded role nurse practitioner concept, and the Joint Practice Committee of the two associations has served in an advisory capacity in this regard.

President Eyes Drug Abuse

Washington, D.C. - President Carter has called for "a conscious and deliberate increase in attention throughout the federal government to the problems related to the abuse of drugs that come originally from legitimate medical sources." Of particular concern are barbituates ..."which are frequently oversold, overprescribed and overused." The Justice Department will..."begin a concerted drive to identify and prosecute physicians who deliberately misprescribe drugs," he said.

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- ☐ dosage forms to meet individual patient needs

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Each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer), 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer), and 25 mg phenobarbital in the immediate release layer

Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

See next page for brief summary.

SUSTAINED ACTION



WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

T-GP-72-B/W

CAUTION: Federal law prohibits dispensing Tedral SA without prescription.

Description. Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Tedral SA: each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital in the immediate release layer.

Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

Tedral Elixir is convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients; porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to *one-quarter* Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

STORE BETWEEN 59° and 86°F (15° and 30°C).

Full information is available on request.

Department of HEW Moves Ahead

Reports from Washington indicate that the Department of HEW has been trying to figure out how to correct its previously published \$100,000 Medicare payments to physicians list since March. Sources state now that the new list will be issued soon with a disclaimer as to the correctness of any of the figures.

On another project, HEW has recently spent many staff hours and thousands of dollars to study and publicize physicians' average net income in 1975. Such figures have been available in the AMA's annual "Profile of Medical Practice" for a number of years. The cost of the "Profile" is \$4.50.

HSA's Cited for Provider Control

The Southern Regional Council in a recent report concerning implementation of the Health Planning Act has concluded that physicians and hospital administrators exert too much influence on most Health Systems Agencies in the South.

The report states that "with the possible exception of the Mississippi Health Systems Agency, Inc., in Jackson, no HSAs in the region are controlled by the consumer board members."

Other problems facing the South's HSA's, according to the council, are: (1) a lack of public involvement in and knowledge of HSA activities; (2) insufficient involvement of consumer members in HSA planning and review; (3) a lack of accountability to the public; (4) a lack of enforcement of federal regulations concerning certificates of need; and (5) insufficient authority to generate effective health planning.

D. C. Leads in Infant Mortality

Health Planners take note! The District of Columbia, not Mississippi, has the highest infant mortality rate in the country. Parenthetically it should be noted, too, that D. C. has more hospital beds, physicians and nurses per population than almost any other area of the country so there must be some other reasons for the high rate rather than the need for more physicians and other health resources as so often stated in Mississippi.

Protection Levels Against Tetanus Fall

The adult population is so nonchalant about tetanus, an AMA publication reveals, "that well over

three-fourths are probably lacking in immunity." The recently published pamphlet, "Tetanus . . . One of the Deadliest Poisons" may be purchased in quantities for distribution to patients. Write AMA Order Department, 535 N. Dearborn St., Chicago, IL 60610.

HEW Regional Directors Are Downgraded

The power of HEW Regional Directors has been shifted to Washington in a move "to provide clear and direct accountability between the program people in the field and their respective headquarters program offices in Washington, according to HEW Secretary Califano." The regional directors, now to be called "principle regional officials," will report to Califano through a new deputy undersecretary for intergovernmental affairs.

Children's Screening Program Is Criticized

After a visit to review Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program in

Mississippi and several other states, the Children's Defense Fund has cited the program a failure.

CDF made the following conclusions from its study of the 10-year-old program in Mississippi and other states:

- Only 56 per cent of all needy children qualify for the program.
- Screenings and health histories aren't thorough. Moreover, most screenings are for the young and fail to consider special needs of adolescents.
- Most screenings can't spot mental and developmental problems.
- Physicians are discouraged from participating in the program because of low fees, delayed reimbursement, paperwork and red tape.
- Most screenings are provided by health departments which can't provide followup care but also fail, 40 per cent of the time, to even refer children with problems to physicians.

The latter conclusion has been confirmed by the American Academy of Pediatrics. It recently cited the failure of the screening program "to link children to an ongoing source of health care."

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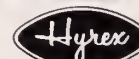
An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

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Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** Adults—1 tablet four times daily. Children—6 to 12 years of age; ½ tablet 3 or 4 times daily. **HOW SUPPLIED:** White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. Literature Available: On request.

Available through all drug wholesalers.



HYREX COMPANY

832 South Cooper
Memphis, Tenn. 38104

The Mississippi Medicaid Commission reports a budget of \$3.8 million for its Early and Periodic Screening, Diagnosis and Treatment Program in fiscal year 1977. The Children's Defense Fund is a nonprofit watchdog and research organization located in Washington, D. C.

Health Care Update Is Scheduled

MSMA and the Mississippi Hospital Association will jointly sponsor a one-day seminar entitled "Health Care Update" on Sept. 16 at the Ramada Inn Coliseum in Jackson.

Congressman David R. Bowen and other national and state leaders will appear on the program to discuss such topics as national health legislation, health care costs and hospital/medical staff relationships.

Complete details on the meeting are available from MSMA. The seminar will be limited to 100 physicians on a "first come-first serve basis."

Medicaid Increase Is Sought

The Physicians' Technical Advisory Committee to the Mississippi Medicaid Commission will meet with members of the commission in September to urge support for an increase in payments to physicians under the program.

Citing increasing costs and declining physician participation in the program, members of the Technical Advisory Committee will attempt to get commission support for the first increase in the Medicaid payment schedule for physicians since the Medicaid program was enacted in Mississippi in 1969.

The present Medicaid payment schedule for physicians was written into the Medicaid Enabling Act by the Mississippi Legislature and the act will have to be amended during the 1978 Regular Session if an increase in payments to physicians is to be authorized.

The physician service benefit is the only Medicaid benefit which has not been increased since the Medicaid program was enacted and the only Medicaid benefit requiring an amendment to the Medicaid Enabling Act to authorize an increase.

The Physicians' Technical Advisory Committee to the Medicaid program is chaired by Dr. Joe S. Covington of Meridian and members are: Drs. Louis C. Lehmann, Natchez; James C. Bass, Jr., Laurel; Thomas W. Wesson, Tupelo; Ralph L. Brock, McComb; and Matthew J. Page, Greenville.

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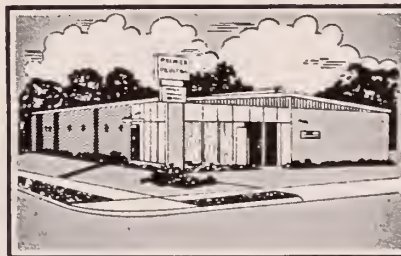
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ORIGINAL PAPERS

Surgical Management of Large Breasts

W. DOUGLAS GODFREY, M.D., H. C. ETHRIDGE, M.D.,
WILLIAM O. BOBO, M.D., and ROBERT A. SMITH, M.D.

Jackson, Mississippi

WHILE THE PATIENT seeking breast enlargement has caught the attention of the press in the past few years and the results of that surgery have been notable, the results of reducing the heavy pendulous breasts have been equally noteworthy. These patients are generally "thunderstruck" by the changes wrought. While breasts that are too small may pose some degree of emotional disability, breasts that are too large always cause significant physical disability. Because of this physical disability, the operation is generally treated as a non-cosmetic procedure by insurance companies. Functional and cosmetically acceptable breasts can be achieved in one stage in 90 per cent of the cases. We have performed 30 reduction mammoplasties in the past year and extreme patient satisfaction has prompted this report.

Etiology

The patients give a history of rapid rate of breast growth during adolescence and early teens. Milk production has been inadequate. Progression of size has occurred in some even into the early twenties.

Numerous papers have dealt with the endocrine problems of breast hypertrophy and this paper will not cover that subject since virginal hypertrophy is poorly understood. None of the patients treated in this group displayed the gigantic breast hypertrophy that has seemed characteristic of those breasts that had a distinct endocrine pattern. At operation, on a gross anatomic basis, it appears that the bulk of the increased size is not due to glandular hypertrophy, but fat hypertrophy. It seems that the cause of breast hypertrophy in a patient is due to a number of factors, and having been moderately overweight in

an early period in life has been only a contributing factor. None of our patients has been markedly obese but approximately one-half were considered overweight at time of presenting.

The authors discuss various techniques by which reduction mammoplasty can relieve patients of the problem of heavy pendulous breasts. They cover etiology, symptomatology, operation and course, and pathology, and relate complications and patient satisfaction, illustrated by two case reports, of 30 cases they performed during the last year.

Symptomatology

The symptoms commonly expressed are difficulty in getting bras large enough to fit, the bra straps cut into the shoulders, shoulder and dorso-lumbar spine pain, and mild paresthesias in ulnar nerve distribution of the hand and forearm.

Jogging or playing active games such as tennis, swimming or golf is avoided because of the sheer size and impediment to arm and shoulder motion. Some of the patients go on reducing diets to reduce the breasts but they seem to lose a disproportionate amount of weight in the rest of the body and the breasts appear relatively larger and always seem to become more pendulous. Most patients with this problem do not complain with pain in the breasts and, indeed, most of them complain that their breasts have no distinct good feeling at all and are certainly not a site or source of erotic pleasure.

Operation and Course

The patient is brought into the hospital the night prior to surgery and with the patient standing, the

From the Division of Plastic Surgery, Mississippi Baptist Medical Center, Jackson, MS.

new nipple site is determined by inspection and by several measurements. It should be situated in the mid-clavicular line along a line that passes through the nipple and it should be at about the level, or slightly above the inframammary crease. Another site to use for reference is the mid arm level. The patients almost always give blood preoperatively for autotransfusion during the course of the operation since most patients lose 700 ml. to 1000 ml. of blood during this operation. The surgery is performed under general anesthesia with the patient recumbent. The nipple is isolated and preserved on a vertical dermal pedicle which is created by excision of the outer layers of skin allowing the deep dermis to be buried with only minimal sequelae. The medial and lateral skin and subcutaneous tissue flaps are developed and the excessive breast tissue and skin is removed from the inferior portions of the breast on either side of the vertical dermal pedicle. Varying amounts of the vertical dermal breast pedicle are finally trimmed as needed to create a breast tissue-skin proportion that creates a well contoured and projecting breast mound. The nipple sits on the apex of the newly shaped breast mass. After hemostasis is accomplished, the lateral flaps are closed caudal to the nipple and the wound is closed in the inframammary crease area and no drainage is provided.¹ Dry gauze dressing is applied with no efforts toward maintaining pressure and the patient receives her bottle of blood during the operation or in the recovery room.

The following day, the patient is placed in a bra that is predetermined to fit and she may go home that day or the next and have the sutures removed between the seventh and twelfth day. The patient

is left with a circumareola scar, a vertical scar from the mid portion of the inferior border of the areola down to the inframammary crease and a scar of varying lengths from medial to lateral coursing in the inframammary crease.

Pathology

The average age at time of surgery was 38 years. The maximum weight of excised tissue was 2100 grams and the average weight was 1306 grams. Five gave a history of having mastitis but only one had ever had a biopsy. Pathological report on tissue removed was benign breast tissue—16; mild chronic focal mastitis—6; virginal hypertrophy—2; ductal fibrosis and proliferation—3; nodular fibrosis—2; adenofibrosis—1. None revealed malignant lesions.

Discussion

Most of the patients are satisfied with their new size and contour and though the scars are extensive, they do not seem to be a source of dissatisfaction even when they become hypertrophic. Usually, if this occurs it will be in the most medial or the most lateral extent of the inframammary incision. Most patients feel well with minimal tenderness in two to four weeks.

If the patient has a history of breast cancer in her family, I feel that mammograms should be obtained six months postoperatively since the buried dermal skin bridge could cause some radiographic questions later. This buried mass has been a diagnostic problem in the early postoperative course of some patients. The operating doctor should follow this since he knows what it should feel like. After six months any new developing mass should be biopsied since these patients do have some slight residual glandular tissue. Patients with strong history of cancer would



Figure 1a. Preoperative.



Figure 1b. Six months postoperative.



Figure 2a. Preoperative—side view.



Figure 2b. Four months postoperative—side view.

probably be better off with amputation type reduction with free nipple graft. Nipple sensation is definitely lost in this procedure.

Complications

No intraoperative or early postoperative complications occurred. One had partial loss of nipple and a portion of the sustaining dermal pedicle. This was anticipated in the hospital but progressed and became a reality after the patient left the hospital. Two drained a large seroma spontaneously at home eight to 10 days postoperatively. Though patients have rarely complained to us, we have noted asymmetry in 10 to 20 per cent and consider this as one type of complication. It can be corrected with minimal secondary surgery, but the patients rarely desire it.

Summary

Patients can safely be relieved of the problem of heavy pendulous breasts by various reduction mammoplasty techniques. Cosmesis is adequate and total patient acceptance is good. Having less breast tissue to examine can be a help in early cancer detection but the mass of buried dermis in some patients can be a temporary problem in detection by palpation techniques. ★★★

508 Medical Arts Building (39201)

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1776—a stitch in time saves nine.

1976—early corrective feedback obviates error preponderancy.

—Insurance Economics Surveys

Management of Pain of Malignancy

R. A. SANFORD, M.D., and B. S. PATRICK, M.D.

Jackson, Mississippi

MANAGEMENT of the pain of advanced malignancy is a universal problem for all primary care physicians. In a survey on the experiences of patients during the last year of life, Cartwright states that pain was the main complaint that led them to the doctor.³ It is impossible to estimate the amount of suffering of patients with terminal malignancy, but the service of keeping cancer patients comfortable and functional is very worthwhile. We will repeatedly emphasize the importance of reducing the amount of incapacitation as well as removing the pain.

Clinical Consideration

Often the physician has only the patient's history to guide him in establishing the diagnosis of pain. The patient's description of his pain usually is the most significant factor in establishing the location of the tumor.

It is important to verify that for each new pain there is an underlying malignancy as the etiology. It is tragic to overlook a treatable lesion such as abscess or incisional neuroma. The physician, while sorting through the patient's description of the type, quality, and intensity of pain usually will be able to determine the severity.

Psychological overlay is always present and must be recognized and treated. The organic component of the pain usually varies in intensity with time and multiple modifying factors such as position, activity or compression.

In cancer pain there is obviously tissue damage and an organic basis for the complaints. However, it is equally important to realize that the patient with terminal illness needs human contact and understanding. Often the patient's only method of gaining attention from his physician is by his complaint. He, therefore, will dwell on his pain as the central problem, when what he really needs is psychological support. There is a great temptation on the part of medical staff to avoid the dying patient. The hospital consultant is especially guilty in this respect and often fails to appreciate the importance of a bedside

conversation. Patients often will look forward to regular medical rounds and prefer to be awakened from sleep rather than be passed by.⁴

This is the second of a series of articles dealing with pain associated with malignant neoplasms. The first, Pain and Malignancy, appeared in the June 1977 issue of the Journal MSMA. The current article discusses management of pain of malignancy and covers clinical considerations, treatment of malignancy, symptomatic management of pain and pain relieving procedures.

It is quite clear in organic disease that pain complaints are not totally a function of peripheral input. General anxiety serves to intensify the pain experience and amplify behavioral responses to pain sensation. An otherwise moderate pain experience will become unbearable when a patient is depressed. Emotional support given by the physician and nursing staff is invaluable. Frank discussion of the disease process and a concrete workable plan of action is a great source of comfort. In the management of pain of non-curable cancers three main approaches will be discussed: (1) The treatment of malignancy, (2) Symptomatic management of pain, (3) Pain relieving procedures.

Treatment

Reduction of the actual cell replication will decrease tumor bulk and its invasion of other organ systems, especially peripheral nerves. Control of cell replication is obviously the first line of defense. Usually, if the tumor makes a factorable response by reduction in size with chemotherapeutic agents, radiotherapy or hormonal manipulation, there will be a decrease in pain. Therapeutic regression of malignancy should be the first consideration in treatment of pain. When malignancies become refractory to treatment or the arrest of cell growth does not reduce the pain, then we should proceed to the next line of defense.

From the Department of Neurosurgery, University of Mississippi Medical Center, Jackson, MS.

Radiotherapy is particularly useful in control of pain of metastasis to the skeletal system. This will often be true even in the less radiosensitive tumors. Radiosensitive tumors such as lymphomas, reticulosarcomas and seminoma, show an excellent pain response.⁶

Reduction in pain often occurs as malignant tumors respond to their respective cytotoxic agents. Again, deposits of leukemia cells and lymphomas respond most quickly. The greatest limitation is that tumor cell replication is halted, but the tumor mass producing the pain is only slowly reduced. Therefore, pain reduction may be insufficient.⁶

One of the most promising medical advancements is hormonal manipulation. Estrogen therapy for control of prostate carcinoma is widely utilized. It is now possible to predict with a high degree of accuracy which breast carcinomas will respond to hormonal ablation by the estrogen binding capacity of the tumor. The majority of tumors which demonstrate estrogen and/or progesterone receptors will respond to hormonal ablation (oophorectomy, adrenalectomy or hypophysectomy). This response is a remission of tumor growth and a simultaneous decrease in pain.

Symptomatic Management

The first line of treatment for most physicians involves analgesic drugs. These drugs are easy to handle for the physician, comfortable for the patient and efficient in a large variety of painful conditions.

It is important to utilize just enough drug to achieve pain relief as quickly as possible. Progression from weaker to stronger drugs is advised to obtain the maximum benefit from each analgesic. This orderly progression will postpone as long as possible the exhaustion of the full number of pain medications.⁴

The difficulty begins when the necessity for usage of narcotics arises. In patients with incurable malignant conditions, the philosophical question of addiction is not particularly a problem. In the patient who has only a limited life expectancy, physical and psychological addiction should not be a limiting factor. However, physical dependence will undoubtedly develop upon repeated administration of even moderate doses of narcotics. Tolerance begins as early as three weeks post regular usage. Tolerance is characterized by decreased duration and intensity of the effect of the drug.

In terms of clinical signs, the first indication of developing tolerance is shortening of the duration of the drug's effect. This is a predictable effect and of course severely limits the beneficial potential for nar-

cotics. As the patient develops dependence to the drug, the dosage has to be increased to continue his previous level of medication for pain relief. The side effects of sedation become a problem. The patient gradually requires a stuporous state for satisfactory pain relief. His life then becomes merely an existence from medication to medication. When anticipated longevity is greater than three to six months, we can expect the problem of tolerance.

Tolerance and physical dependence are manifest by the appearance of withdrawal symptoms and signs when the drug is discontinued. The severity of the syndrome is more intense the higher the dose and the longer the duration of administration of the narcotic. It is unwise to substitute non-narcotics, such as Talwin, for these patients with physical dependence.

Therefore, the utilization of narcotics in chronic pain patients must be carefully evaluated in light of the patient's future. If the narcotics need to be given multiple times per day for greater than 3-6 months, some other form of pain relief should be sought. The narcotic then will remain a valuable adjunct to be used at a later stage of disease.

The importance of the supplemental drug should not be overlooked. Psychologic depressive states are quite common in patients with terminal malignancies. The addition of anti-depressive medications can be very helpful. The two groups of medications commonly used are monamine oxidase inhibitors and tricyclic anti-depressants.⁵

Pain Relieving Procedures

Neurosurgical procedures are utilized with malignancies beyond radiotherapy, chemotherapy, surgical or hormonal control.

Although neurosurgical intervention should be considered a last resort, it is the authors' opinion that it should not be delayed unnecessarily. Surgical intervention should ideally proceed at a time when narcotic dependence can be predicted. It is quite tragic to interrupt the pain pathway leaving a potentially active functional person only to have him require narcotics.

Basically, the technique of neurosurgical intervention involves the interruption of pathways between the source of pain and its recognition by the cerebral cortex. The pain pathway may be interrupted peripherally by sectioning the nerve or nerve root prior to its entrance into the central nervous system. Sectioning the nerve itself involves the de-innervation of muscle groups as well as the loss of painful sensation. This is useful in the thoracic re-

MALIGNANCY / Sanford and Patrick

gion in which intercostal musculature may be sacrificed. The section of nerve roots may be done either chemically or surgically.

Once pain has entered the spinal cord, it divides into two separate pathways. The direct, well understood lateral spinal thalamic tract is carried through the spinal cord, brain stem, thalamus to its cortical representation. There is a secondary pain pathway which is a multi-synaptic pathway that travels through the central gray of the spinal cord and via the reticular formation and the diffuse intra laminar thalamic system. Interruption of either system will relieve pain. The direct oligosynaptic system (lateral spino-thalamic) is the most commonly sectioned. Interruption of this pathway (cordotomy) prevents the sensation of pain and temperature from reaching cortical awareness.

The third and least commonly used method of relieving pain is interruption of appreciation for pain and its emotional component by a central nervous system lesion. These lesions may be produced in the frontal lobe, cingulate gyrus or nuclei in the thal-

amus thereby decreasing the patients' appreciation of pain. These procedures are useful in widespread malignancy with severe mental anguish and suffering.

The next article in this series will discuss these procedures in more detail with specific indications for each.

★★★

2500 North State Street (39216)

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Radiologic Seminar CLXXIII: Odontoid Fracture

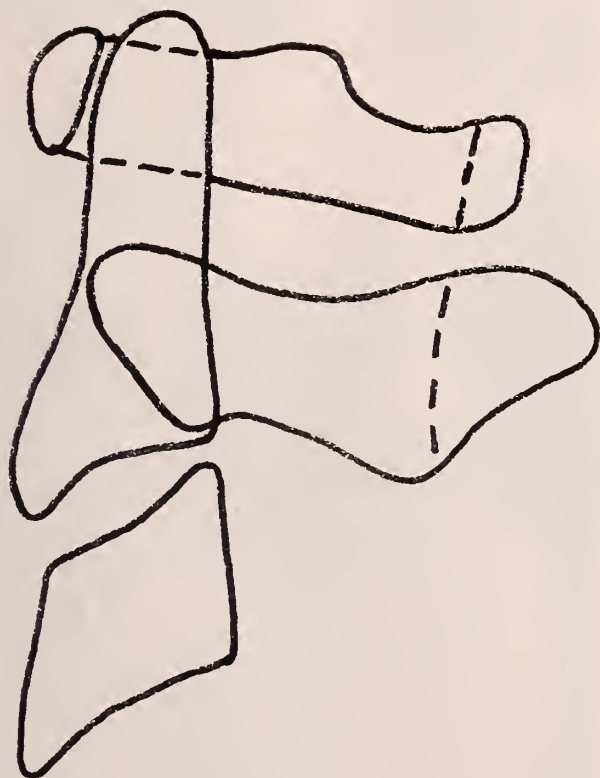
ALLEN YATES, M.D.
Jackson, Mississippi

ODONTOID FRACTURES result from sudden hyperflexion or hyperextension trauma of the head.^{1, 4} The presenting complaint is often only a painful stiff neck without any neurological signs.^{1, 2} Anderson, et al, have categorized these fractures as Type I or avulsion fracture of a portion of the tip of the ends, Type II or transverse fractures through the body or base of the odontoid, and Type III or fractures angled across the odontoid base and down into the vertebral body.³ Type I is rare and as a rule is not unstable and therefore will not be discussed further here.³

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist Medical Center, Jackson, MS.

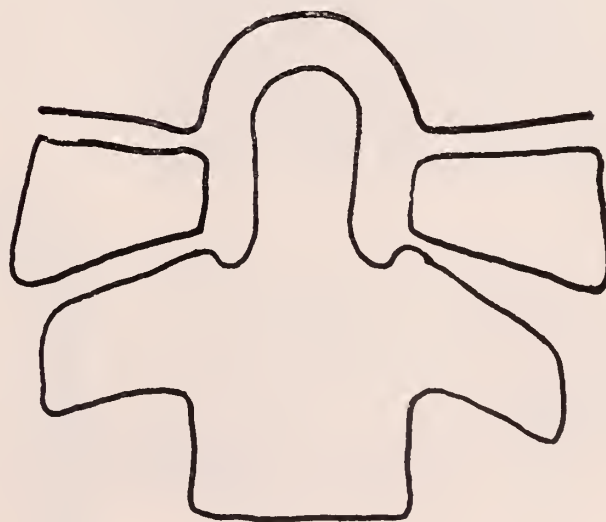
Displaced transverse (Type II) odontoid fractures are usually readily recognized; however, non-displaced fractures of this variety and the Type III fractures angled into the vertebral body may present with only minimal abnormality. These subtle fractures may be overlooked unless one is familiar with the normal anatomical relationships of the odontoid process with the C-2 vertebral body and the atlas.

The normal lateral schematic diagram in Figure 1(a) shows the continuity of the cortical margins of the odontoid with the C-2 vertebral body. The posterior cortical margins are essentially straight and the axis of the odontoid is essentially parallel with the posterior margin of the vertebral body. The an-



(a)

Figure 1 (a). The normal axis of the odontoid is essentially parallel to the continuous posterior cortical margins of the odontoid and the vertebral body. (b). The



(b)

odontoid axis is perpendicular to the base of the vertebral body and equidistant between the lateral masses.



Figure 2. Type II hyperextension transverse odontoid fracture with disruption of cortical margins and posterior displacement. Angulation is moderate.

terior atlas ring is closely applied to the odontoid and its anterior margin usually lines up with the anterior margin of the C-2 vertebral body. Figure 1(b) in the frontal view shows the normal odontoid to project upward equidistant between the two lateral masses and articular facets of C-2 with its axis being perpendicular to the inferior surface of the vertebral body.

Characteristic posterior displacement and angulation of the odontoid with obvious interruption of cortical margins in a Type II hyperextension fracture are demonstrated in Figure 2. The Type III flexion fracture in Figure 3 shows minimal anterior angulation of the odontoid axis and subtle malalignment and discontinuity of the posterior cortical margin at the base. The anterior margin of the atlas ring is very slightly anterior to its expected position. Fol-



Figure 3. Type III flexion fracture with subtle anterior angulation and discontinuity of cortical margins and slight anterior displacement.

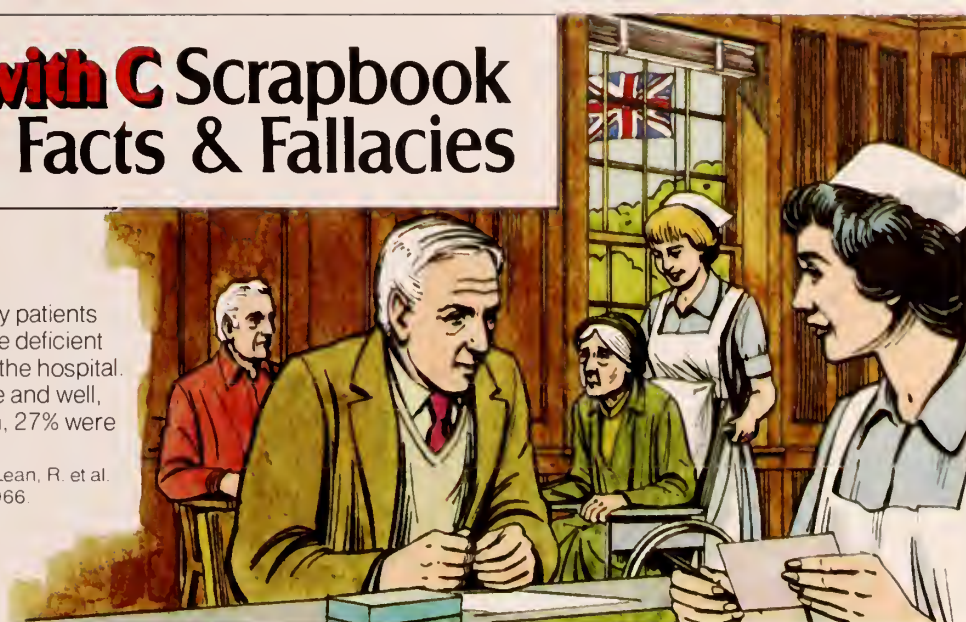


Figure 4. Frontal tomogram demonstrates the Type III fracture line angling across the base and into the vertebral body. (Same patient as in Figure 3).

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Griffiths, L. L., Brocklehurst, J. C., MacLean, R. et al.
Diet in Old Age, Brit. Med. J., 1:739, 1966.



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low-up tomographic examination of this patient in the frontal projection (see Figure 4) demonstrates a prominent fracture angling through the odontoid base and into the vertebral body.

The occasional subtlety of odontoid fracture is exemplified by the second case (see Figures 3 and 4) and points up the necessity of technically satisfactory films and further evaluation of any suspicious abnormality. Failure to recognize odontoid fractures can have catastrophic consequences in the acute phase. Older untreated fractures particularly of Type II may undergo non-union or pseudoarthrosis with late development of myelopathy and

are at high risk of neurological sequelae from relatively minor neck trauma.^{1, 3} ★★★

1151 North State Street, Suite 316 (39201)

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AN OLD FABLE

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U. S. Congress, 1964

PHYSICIANS' PUBLIC RELATIONS

"There are 2.9 million visits per day between patients and physicians. It is the way in which we as individual physicians deal with people as individual patients that counts and forms public opinion, not what the media says."

DR. JAMES H. SAMMONS

AMA Executive Vice President



The President Speaking

Danger Ahead: Rationing of Care

JAMES O. GILMORE, M.D.
Oxford, Mississippi

In medicine as in other purchases, the buyer gets what he pays for. There is no steak-house medicine at hash-house prices. Prices of care cannot be harshly cut without cutbacks in the quality or quantity of care.

Those hard-boiled truths are obvious to us physicians, who deal with costs as a day-to-day reality rather than a pliable abstraction. And in its somewhat devious way, the federal government seems to perceive those truths, too.

The government's cluster of programs and proposals for containing costs is made to look like pure benefit for the patient, without any actual loss on his part. What they generally boil down to upon analysis, however, is rationing of care.

This was a central point—and a central danger—posed by Richard E. Palmer, M.D., in addressing the AMA's annual convention last June as its outgoing president. Dr. Palmer identified rationing of care as a common denominator of proposed restraints in so-called unnecessary surgery covered by public funds, HMOs, the Health Planning Act of 1974, the push for generic drugs, and the proposed "cap" on hospital charges as a prelude to the Administration's National Health Insurance proposal.

On the proposed ceiling on hospital charges, he asked:

"Is it not predictable that the most creative, resourceful, and conscientious hospitals would suffer from such economic artifice? Or that in treating all hospitals alike, the cap would penalize those that are already efficient, as a Senate health expert was quoted?"

Apropos hospitals, it also must be recognized that some lack efficiency; that some communities are over-bedded; and that costs—the number one health-care concern of the public—can be restrained without disastrous results to quality. The medical field—through such means as the AMA's Commission on the Cost of Medical Care—must do its practical best against the economics that encourage federal rationing of health services.

In the matter of HMOs, Doctor Palmer noted that these have been hailed on Capitol Hill as "a great piece of ammunition" against rising medical costs. But what about the amount of care? he wondered. Recent studies indicate that HMO physicians see their patients less often and give less service—including preventive care—than do fee-for-service physicians.

Shrinkage of service also could be the upshot of any NHI program that would ape Britain's National Health Service, said Dr. Palmer. For it has happened there.

As he summed up: "No individual—and ours is a nation of individuals—wants his care to fall victim to cost-effective common denominators. No individual wants his own care to be rationed."

Physicians at the local level should get this point across—as the government sharpens its ax against necessary costs. ★★★

**New Medical Discipline
Law Takes Effect**

During the 1977 Regular Session of the Mississippi Legislature an MSMA-sponsored proposal which significantly strengthens state statutes dealing with medical discipline was adopted by both houses and signed into law by the Governor. SB 2031 essentially grants the physician members of the State Board of Health the authority to initiate disciplinary action against any physician who (1) exhibits professional incompetency in the practice of medicine or surgery; or (2) has had disciplinary action imposed by a local, state, or national medical society or by a hospital or medical staff of such hospital.

SB 2031 was one of nine measures that the House of Delegates, meeting in special session in October 1975, urged the Legislature to adopt in an effort to curb the growing professional liability insurance crisis.

Although the thrust of SB 2031 as conceived by the House of Delegates is directed at providing a mechanism for proceeding against the incompetent physician, the law, which is based on the AMA's "Model Medical Discipline" legislation, also strengthens that portion of our existing Medical Practice Act which relates to the grounds and manner for taking disciplinary action against a licensed physician.

Section 3 of the law provides that whenever disciplinary action for professional incompetency is being considered by the board, one or more physicians shall be appointed to investigate before charges are brought.

Section 4 sets out the various actions which the board may impose against a physician for violating any of the various grounds necessitating the sanction. These sanctions include:

- (a) Deny his application for a license or other authorization to practice medicine;
- (b) Administer a public or private reprimand;

- (c) Suspend, limit or restrict his license or other authorization to practice medicine for up to five (5) years, including limiting the practice of such person to, or by the exclusion of, one or more specified branches of medicine, including limitation on hospital privileges;

- (d) Revoke his license or other authorization to practice medicine;

- (e) Require him to submit to care, counseling or treatment by physicians designated by the board, as a condition for initial, continued or renewal of licensure or other authorization to practice medicine;

- (f) Require him to participate in a program of education prescribed by the board; or

- (g) Require him to practice under the direction of a physician designated by the board for a specified period of time.

None of these actions may be imposed, however, until the accused has been given a full hearing on the evidence, unless the delay attendant to a full hearing would seriously jeopardize or endanger the public health, in which case disciplinary sanctions may be imposed without a hearing, provided one is held within 15 days after imposition of the action. The law also provides that the physician against whom disciplinary action is taken may appeal the board's ruling to the chancery court.

Additionally, the new law grants statutory authority for any hospital, after consultation with its medical staff, to suspend, deny, revoke or limit the privileges of any physician for professional incompetency provided the medical staff by-law requirements for a due process hearing are complied with.

Sections 6 and 7 of the law also contain a broad immunity provision which protects from liability any individual, board, medical society or hospital from taking good faith disciplinary action against a physician or assisting the Board of Health in carrying out its responsibilities under the act.

One of the most important provisions of the law that should be remembered by medical societies, hospitals and medical staffs is the requirement that any medical staff or society that imposes disciplinary sanctions on one of its members *shall* report such action to the Board of Health within 30 days.

The enactment and implementation of SB 2031 should go a long way toward strengthening public confidence in the medical profession's desire and ability to police its own ranks.

WILLIAM F. ROBERTS
Assistant Executive Secretary
and Legal Counsel

Physicians and the New Rehabilitation Acts

The rehabilitation act of 1973 (Public Law 93-112) and related amendments, rehabilitation act amendments of 1974, are designed to eliminate discrimination on the basis of a physical or mental handicap in any federal assistance program. These laws apply to each recipient of federal assistance from the Department of HEW and to each program or activity that receives or benefits from such programs. A recipient is defined as any state or its political subdivisions, any instrument of a state, any public or private agency, institution, organization or other entity, or to any person to which federal assistance is extended directly or through another recipient, assignee or transferee. A recipient may not discriminate on the basis of handicap in providing any aid, assistance, or benefit under such programs.

Subpart F of section 504 deals with health, welfare and social services rendered under federal programs and thus includes the activities of physicians relating to these programs. The law specifically includes Medicaid as one of the regulated areas while Medicare is exempt. The *Federal Register*, vol. 42, no. 86, May 4, 1977, points out that HEW considers the arrangement under which individual practitioners, hospitals, and other facilities receive reimbursements under Part B of the Title XVIII of the Social Security Act constitutes a contract of insurance or guaranty and thus falls within the exemption from the regulations defining assistance programs.

The secretary (HEW) believes Medicaid providers should be regarded as recipients and should be individually responsible to the law. This is presently interpreted to mean that physicians accepting any patient on a federal program must accept any handicapped patient on that program and provide the necessary facilities to see such patients (wheel

chair ramps, toilet facilities, aids for the deaf and blind, etc.). A physician unable to do this must then see the patient in a facility affording such accommodations or refer the patient to another physician with such facilities. Some have interpreted this to mean that if you cannot accommodate a handicapped patient in your office facility, you must make a house call. Failure to follow the law will forfeit participation in the program.

The act does not define a list of specific diseases or conditions that constitute physical or mental handicaps, but lists categories such as orthopedic, visual, hearing, speech, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illnesses, drug addiction and alcoholism. It is very apparent that the law goes far beyond the time-honored concepts of the term "handicapped" and attempts to legislate participation in many of the social ills affecting society today.

Since this law was passed without any hearings being held by the congress, the Department of HEW has been able to write all rules and regulations relating to the law without knowledge as to the intent of congress in many areas. As presently interpreted, this act will weaken support for and participation in many programs by physicians. Upon application of Public Law 93-112, I foresee even greater difficulties for the Medicaid program than those present today.

MYRON W. LOCKEY, M.D.
Associate Editor

Medico-Legal Brief

Expert Testimony Required for *Res Ipsa Loquitur* Instruction to Jury

A jury instruction on *res ipsa loquitur* was properly denied in a suit where the nature of the alleged malpractice and injuries were not matters plainly within the common knowledge of laymen, a Texas appellate court ruled.

In the summer of 1969, a radiologist treated plantar warts on a patient's left foot. In January 1973, an ulcer developed in the area from which the warts were removed. An orthopedic surgeon who treated the foot diagnosed the condition as a non-healed radiation ulcer.

The patient and her father sued the radiologist, alleging that he was negligent in failing to properly administer the x-ray treatment, in failing to properly observe the variables important to such treatment, in failing to administer the proper dosage of radiation, and in giving the treatment for an excessive period.

The patient alleged that the equipment causing harm was under the radiologist's exclusive control, which was shown to be true at the trial. The patient invoked the doctrine of *res ipsa loquitur*.

The radiologist testified as to the probability of complications resulting from proper radiation treatment. He said that although injury did not ordinarily occur if proper care was used, things sometimes happened that could not be explained.

The trial court refused to instruct the jury on *res ipsa loquitur*. The jury was given an instruction that any circumstance showing merely a lack of success was not evidence of negligence and that negligence could not be inferred solely from a failure to cure or an unexpected result. The jury found that the patient had sustained a radiation injury to her foot while under the radiologist's care, but found no negligence.

On appeal, the patient complained of the trial court's refusal to instruct the jury on *res ipsa loquitur*. The court said that *res ipsa loquitur* could be applied to cases where an accident was such that it would not ordinarily occur in the absence of negligence and where the instrumentality causing an injury was under the sole management of the party being sued. In Texas, however, use of the doctrine was limited to instances where the nature of alleged malpractice and injuries was plainly within the common knowledge of laymen and required no expert testimony.

In the present case, the court pointed out, use of x-ray apparatus was not a matter within the common knowledge of laymen. Further, although it had been shown that the radiologist was in control of the x-ray equipment, there was no expert testimony that the epidermal damage suffered by the patient did not ordinarily occur in the absence of negligence. Although the result was somewhat rare, the court said, this did not give rise to the inference of negligence.

The patient also contended that the trial court erred in the jury instruction that was given. The court agreed, saying that there was some evidence that the radiologist administered an improper dosage of radiation and the jury was entitled to consider the radiation burn along with the other evidence in order to determine whether or not the radiologist was negligent.

The court reversed the trial court judgment and sent the case back for further proceedings.—*Irick v. Andrew*, 545 S.W.2d 557 (Tex.Ct. of Civil App., Dec. 29, 1976; rehearing denied, Jan. 19, 1977)

PERSONALS

BRUCE ATKINSON of Amory announces the relocation of his office to Physicians and Surgeons Clinic on South Boulevard Drive for the practice of internal medicine.

ROBERT L. BARRETT has associated with DONALD A. HOPKINS of Gulfport for the practice of general and vascular surgery at Gulfport Surgical Clinic, 1245 Broad Avenue.

PAUL D. BELFORD announces the opening of his office for family practice at St. Joseph Medical Plaza in Meridian.

J. THOMAS BALZLI has associated with The Eye, Ear, Nose and Throat Clinic of Vicksburg at 1901 Mission 66 for the practice of ear, nose and throat, facial plastic, maxillofacial and head and neck surgery.

HORACE H. BAGGETT announces the opening of his office for the practice of pediatrics at 2165 South Lamar in Oxford.

BERNARD H. BOOTH of Jackson has been elected to fellowship in the American Academy of Allergy.

JAMES E. BOOTH of Eupora was named "Rotarian of the Year" at the annual banquet. Dr. Booth was honored as the Rotarian having best exemplified the high principles of the organization.

DAVID W. BREWER, JR., has associated with Rush Medical Group, P.A. for the practice of obstetrics and gynecology at 1314 19th Avenue in Meridian.

RICHARD G. BURRIS has opened his office for family practice at the clinic building adjacent to Lawrence County Medic Center across from Highway 27 South in Monticello.

WILLIAM H. BURROW, II, announces the opening of his office for the practice of dermatology at Suite 205, Medical Arts Building, 1151 North State Street in Jackson.

FE CABANERO has joined the Warren County Health Department at Vicksburg as a clinician in obstetrics and gynecology.

KENNETH CARGILE has associated with the Family Medical Clinic of New Albany, P.A. for the practice of family medicine on Oxford Road.

THOMAS M. CARR, JR., and DOYLE F. SUMRALL an-

announce the opening of their offices for the practice of internal medicine at 420 Magazine Street in Tupelo.

JOSEPH J. CHAPPELL, JR., announces the opening of his office for the practice of ophthalmology at 610 Brunson Drive in Tupelo.

JULIUS M. COLLUM and RICHARD E. RHODEN of Jackson announce the opening of Crestmoor Clinic to offer neuropsychiatric services for children and adults at 1052 Riverside Plaza.

ROBERT COOPER has associated with R. L. HOLLEY and L. G. HOPKINS of Oxford for the general practice of medicine at 2200 South Lamar Boulevard in Oxford.

PHILIP E. CRANSTON of Jackson has joined the staff of St. Dominic Hospital as a radiologist.

THOMAS D. CROWSON has joined Internal Medicine Associates, P.A. for the practice of gastroenterology and internal medicine at 1301 20th Avenue in Meridian.

WALTER E. DAWKINS has associated with JOE HERINGTON of Natchez for the family practice of medicine at Morgantown Clinic, 118 Morgantown Road in Natchez.

QUINTON DICKERSON of Jackson has been named director of the new Mississippi Heart Institute department at St. Dominic Hospital. Medical directors in the new department are HENRY TYLER, CVS; JEFF HOLLINGSWORTH, CVR and CVSC; and JAMES CROSTHWAIT, noninvasive lab and Coronary Care Unit; JAMES HAYS, EKG services; and WILLIAM ROSENBLATT, chairman of the Cardiovascular Committee of the Medical Staff.

THOMAS C. FENTER has associated with CHARLES D. SCRUGGS and W. MEREDITH BRADFORD of Jackson for the practice of urology at Jackson Urological Clinic, 745 Carlisle Street.

JAMES W. FITE has associated with ROBERT L. COGIN of Grenada for the practice of pediatrics at 965 Avent Drive.

ALPHONSUS FLANNERY has associated with THOMAS R. WILLIAMS and BEN E. KITCHENS of Iuka for the general practice of medicine at the Iuka Family Clinic, 302 Kaki Street.

H. ALAN FLOWERS and JOSEPH N. BAILEY, III, have joined Internal Medicine Associates of Tupelo, Ltd., for the practice of internal medicine and gastroenterology (Dr. Bailey) at 806 West Garfield Street.

L. H. FULCHER, JR., of Jackson has been elected president of the Jackson Music Association.

WADE S. GARNER announces the opening of his new office at 2026 Commerce Street in Grenada for the practice of internal medicine.

GARY H. GROFF has associated with E. M. BAUMHAUER, JR., and ROBERT L. DONALD, JR., for the practice of family medicine at Suite 202, Doctors Plaza, 4211 Hospital Road in Pascagoula.

ORIN F. GUIDRY and KARL E. BECKER, JR., of Jackson have associated with Anesthesia Associates at 301 Medical Plaza Building, 1600 North State Street in Jackson.

CLYDE O. HAGWOOD, JR., of Biloxi, has relocated his office to the second floor, Coastal Medical Center Building, Gateway Executive Park in Biloxi.

JOHN F. HASSELL has associated with The Laurel Family Clinic at 103 South 12th Avenue in Laurel for family practice with Drs. Hollingshead, Casey and Balaski.

HENRY HILLMAN announces the opening of his office for the practice of family and internal medicine at Medical Plaza Building, Suite 105, 127 Lameuse Street in Biloxi.

JAMES J. HUDGINS has associated with Jackson Surgical Group for the practice of general and vascular surgery at 514-A East Woodrow Wilson.

VAN L. LACKEY has associated with GUY T. GILLESPIE, JR., of Jackson for the practice of hematology and oncology at 700 Gillespie Street.

KERMIT LAIRD and RAY LYLE of Starkville were guest speakers on the local community television program, "Views." The topic was regional hospitals.

LAWRENCE MAHALAK, JR., announces the opening of his office for the practice of neurology at 1815 Hospital Drive, Suite 380, in Jackson.

K. N. MANIKTAHLA announces the opening of his office at South Panola Community Hospital, Highway 6 West, in Batesville, for the practice of urology.

ROGER MARLIN of Fulton, formerly with the National Health Service Corps, has purchased the former office of A. P. SPRABERRY to set up his private practice of medicine in Fulton.

MALCOLM MCAULEY has associated with HAROLD K. HUDSON and ROGER L. LOWERY of Tupelo for the practice of ear, nose and throat, head and neck

facial plastic surgery, and allergy at 618 Pegram Drive in Tupelo.

T. SCOTT McCAY of Jackson has been appointed director of radiology at St. Dominic Hospital.

T. O. McRANEY has opened his medical practice in the Kety Clinic on Fifth Avenue in Picayune.

WILLIAM A. MORRISON has associated with BRUCE M. M. MCCARTHY at the Hattiesburg Clinic Professional Association for the practice of orthopedic surgery.

RICHARD NICHOLLS and EDWARD S. HOFFMAN of Pascagoula announce the relocation of their offices for the practice of ob-gyn to 2812 Andrews Avenue.

B. R. PATEL has opened his office for family practice in the Medical Arts Building, 1203 Jefferson Street in Laurel.

ANTHONY B. PETRO has associated with RICHARD L. YELVERTON and WALTER R. JONES, JR., of Jackson in the practice of general, thoracic and vascular surgery at Suite 310, St. Dominic Medical Offices, 971 Lakeland Drive.

MARTIN POMPHREY has associated with JOHN G. GASSAWAY of Starkville for the practice of orthopedic surgery at Starkville Orthopedic Clinic on Academy Road.

THOMAS H. PRICE has associated with RUSSELL R. LYLE of Starkville for the practice of pediatrics and adolescent medicine at 517 University Drive.

THOMAS PURSER, III, announces the opening of The Orthopedic Clinic for the practice of bone and joint surgery at 1000 5th Avenue in Picayune.

ANN ROBERTS has joined SUE SIMMONS of Maben in the practice of general medicine at Tom Bailey Memorial Clinic in Maben.

JOSEPH H. ROBINSON announces the opening of his office for the practice of dermatology at Suite 103, Medical Plaza, 1600 North State Street in Jackson.

SIDNEY O. ROSS, JR., has associated with C. FOSTER LOWE of McComb for the practice of surgery at Medical Arts Building, 300 Rawls Drive.

R. P. (SKIP) RUSSELL announces the opening of his office at St. Dominic Medical Offices, 971 Lakeland Drive, Suite 620, in Jackson for practice of ophthalmology.

NATHAN P. SHAPPLEY has associated with TOXEY M. MORRIS of Hattiesburg for the practice of pediatric and adult urology at 405 South 28th Avenue.

BENJAMIN SIMO has opened his office at 300 Rawls

Drive, Suite 1000, Medical Arts Building in McComb for the practice of urology.

JAMES Q. SONES has associated with Jackson Medical Associates, P.A. for the practice of gastroenterology and internal medicine at Suite 200, Medical Plaza Building, 1600 North State Street in Jackson.

HUGH STANCILL, III, and GERALD HARPER announce the opening of their practice of obstetrics and gynecology at 305 South Magnolia in Laurel.

DOUGLAS L. STRINGER has associated with Drs. Neill, Neill, Hodges and Warren of Jackson for the practice of neurological surgery and microneurological surgery at Suite 414, Medical Arts Building in Jackson.

TOMMY SWEAT of Corinth has been named to the Board of Trustees of Magnolia Hospital.

R. R. TADROS has joined the staff of North Panola Regional Hospital and Nursing Center in Sardis for the practice of general and vascular surgery.

MATTHEW B. WESSON has associated with THOMAS W. WESSON, SR., and THOMAS W. WESSON, JR., of Tupelo for the practice of ophthalmology at 612 Brunson Drive.

PAUL J. VILARDI announces the opening of his office for the practice of orthopedic surgery and diseases of the musculoskeletal system at Houston Hospital in Houston.

CHARLTON R. VINCENT of Laurel has been awarded a full professorship in obstetrics and gynecology at LSU Medical School in New Orleans. Residents from Charity Hospital in New Orleans will rotate through the Laurel clinic and obstetrical unit of Jones County Community Hospital.

NEW MEMBERS

ACHORD, JAMES LEE, Jackson. Born Dayton, Ohio, Sept. 24, 1931; M.D., Emory University School of Medicine, Atlanta, GA, 1956; interned, same, one year; residency in internal medicine, Emory and Grady Hospitals, Atlanta, 1960-62; elected by Central Medical Society.

APPLEWHITE, ROBERT REX, Laurel. Born Bassfield, MS, Sept. 24, 1940; M.D., Louisiana State University School of Medicine, New Orleans, LA, 1966; interned Charity Hospital, New Orleans, one year; general surgery residency, same, 1969-73; elected by South Mississippi Medical Society.

NEW MEMBERS / Continued

BRISENO, OSCAR J., Bay Springs. Born Mexico, Apr. 10, 1944; M.D., University of Mexico Medical School, 1968; interned Cook County Hospital, Chicago, IL, one year; surgery residency, Wayne State University, Detroit, MI, 1971-72, Henry Ford Hospital, Detroit, 1972-73, St. Francis Hospital, Peoria, IL, 1973-75; fellowship in cardiovascular surgery, University of Illinois, 1975-76; elected by South Mississippi Medical Society.

CAMIATOS, GEORGE J., Natchez. Born Mytilene, Greece, Aug. 8, 1937; M.D., Faculty of Medicine University of Thessaloniki, Greece, 1969; interned Charity Hospital, Pineville, LA, one year; elected by Homochitto Valley Medical Society.

COOK, LEWIS H., Lambert. Born Columbia, MS, June 30, 1915; M.D., University of Tennessee College of Medicine, Memphis, 1956; interned St. Joseph, Memphis, one year; elected by Clarksdale and Six Counties Medical Society.

GARNER, MABEL T., Fayette. Born Sharon, MS, June 11, 1931; M.D., Meharry Medical College School of Medicine, Nashville, TN, 1959; interned Hubbard Hospital, Nashville, TN, one year; elected by Homochitto Valley Medical Society.

GWIN, JOHN V., Laurel. Born Anniston, AL, Apr. 23, 1912; M.D., Tulane University School of Medicine, New Orleans, LA, 1936; interned U. S. Marine Hospital, New Orleans, one year; EENT residency, EENT Hospital, New Orleans, 1938-40; elected by South Mississippi Medical Society.

JACKSON, A. C., JR., Jackson. Born Houston, TX, Nov. 8, 1941; M.D., University of Texas Southwestern Medical School, Dallas, 1969; interned Boston Navy Hospital, Chelsea, MA, 1969-70; urology residency, Navy Regional Medical Center, Oakland, CA, 1971-75; elected by Central Medical Society.

JACKSON, WILLIAM G., Corinth. Born Louisville, KY, Sept. 24, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned Baptist Memorial Hospital, Memphis, TN, one year; elected by Northeast Mississippi Medical Society.

KULIK, FRANK A., Jackson. Born Binghamton, NY, May 26, 1938; M.D., University of Maryland School of Medicine, Baltimore, 1968; interned South Baltimore General Hospital, MD, one year; psychiatry residency, New York Medical College, New York, NY, 1969-72; elected by Central Medical Society.

MARTIN, JAMES M., Hattiesburg. Born Honolulu, Hawaii, Oct. 18, 1931; M.D., Washington Univer-

sity School of Medicine, St. Louis, MO, 1956; interned St. Louis City Hospitals, St. Louis, one year; internal medicine residency, same, 1957-58; radiology residency, same, 1958-62; elected by South Mississippi Medical Society.

ODOM, TERRY W., Amory. Born Murfreesboro, TN, May 23, 1948; M.D., University of Tennessee College of Medicine, Memphis, 1973; interned City of Memphis Hospitals, Memphis, one year; pediatrics residency, same, 1974-76; elected by Northeast Mississippi Medical Society.

PASLAY, JEFFERSON W., Clarksdale. Born Charleston, MS, Dec. 8, 1923; M.D., University of Tennessee School of Medicine, Memphis, 1949; interned Knoxville General Hospital, one year, Knoxville, TN; aerospace medicine residency, 1958-60; master of public health, 1960-61; elected by Clarksdale and Six Counties Medical Society.

RAJU, SESHADRI, Jackson. Born Delhi, India, July 13, 1939; M.D., Christian Medical College, Punjab University, Ludhiana, Punjab, 1961; interned, same, one year; surgery residency, same, 1963-67; research fellowship, UMC, Jackson, MS, 1968-69; cardiovascular residency, same, 1969-72; surgery residency, UMC, Jackson, 1974-75; elected by Central Medical Society.

VISE, W. MICHAEL, Jackson. Born Meridian, MS, Oct. 18, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned University of Virginia Hospital, Charlottesville, one year; surgery residency, Ohio State University Hospital, Columbus, 1970-74; Wan Wagemem Traveling Fellow of the American Association of Neurological Surgeons, 1975-76; elected by Central Medical Society.

WILKES, THURSTON E., II, Oxford. Born Cleveland, MS, Oct. 19, 1941; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned, same, one year; urology residency, LSU, Shreveport, 1972-76; elected by North Mississippi Medical Society.

POSTGRADUATE CALENDAR

Oct. 17-21, 1977

FAMILY PRACTICE REVIEW

Holiday Inn Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Family Medicine and University Medical Center Division of Continuing Health Professional Education.



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

- **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.
- **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.
- **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg/kg/day in rabbits and 10 mg/kg/day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG 
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert[®]/25 
(meclizine HCl) 25 mg. Tablets
for vertigo*

GET MOVING, AMERICA!

It feels good to feel fit
physically, mentally, emotionally
So learn a skill you can play for life.



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TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE **DYAZIDE[®]**

Each capsule contains 50 mg. of Dyrenium[®] (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:

Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

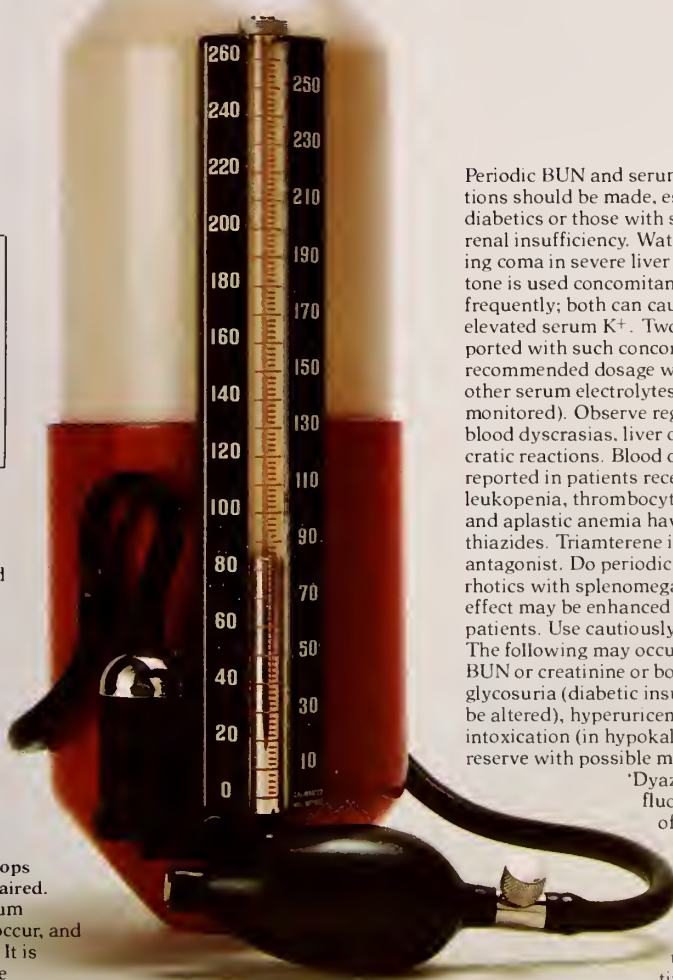
nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

**FOR LONG-TERM CONTROL
OF HYPERTENSION*
SERUM K⁺ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company



B.W.CO.® HAS PUT MORE POTENCY IN THE LINE



EMPRACET® with Codeine Phosphate, 60 mg, No. 4 Ⓢ

EMPRACET® with Codeine Phosphate, 30 mg, No. 3 Ⓢ

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or codeine.

WARNINGS: Drug dependence. Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients. Caution patients that these products may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

PRECAUTIONS: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritus.

DRUG INTERACTIONS: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.

Introducing **EMPRACET®** **Ⓢ CODEINE #4**

Each tablet contains: codeine phosphate,
60 mg (1 gr) (Warning—may be habit-forming);
and acetaminophen, 300 mg.



Our new non-aspirin/ codeine analgesic for moderate to severe pain.

New peach-colored Empracet Ⓢ Codeine #4 offers a potent alternative for patients in whom aspirin is not indicated.

Unlike compounds containing oxycodone which afford comparable analgesia, new Empracet Ⓢ Codeine #4 gives you CIII prescribing convenience—up to 5 refills in 6 months at your discretion (where state law permits). And, prescribing by telephone is permissible in most states. Moreover, new Empracet Ⓢ Codeine #4 has less addiction potential than does oxycodone.

For those of your patients requiring a less potent analgesic, non-aspirin Empracet® Ⓢ Codeine #3 provides effective relief of moderate pain.

Burroughs Wellcome Co. makes codeine combination products. You make the choice.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Coordinators: Ian Cameron, M.D., assistant professor of family medicine, University of Mississippi School of Medicine and Roland B. Robertson, M.D., assistant vice chancellor for Veterans Administration affairs and acting director of Continuing Health Professional Education, University of Mississippi Medical Center, and assistant professor of medicine, University of Mississippi School of Medicine.

This week-long course is designed for the primary care physician who wants to review new developments in family practice in preparation for the family medicine board examination. Fee: \$150. Credit: 40 contact hours, 4.0 CEU, Category 1, AMA; AAFP.

Nov. 10-11, 1977

CARDIOVASCULAR REVIEW—1977

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Departments of Surgery, Medicine and Pediatrics and University Medical Center Division of Continuing Health Professional Education.

Coordinator: James D. Hardy, M.D., professor of surgery and chairman of the department, University of Mississippi School of Medicine.

This two-day course is for internists, cardiovascular surgeons and general practitioners who deal with cardiovascular problems. Guest faculty are Jay P. Sanford, M.D., dean, School of Medicine, Uniform Services University of the Health Sciences, Bethesda, MD; Jeremiah Stamler, M.D., professor of community health and preventive medicine and chairman of the department, Northwestern University School of Medicine, Chicago, IL; J. Willis Hurst, M.D., professor of medicine and chairman of the department, Emory University School of Medicine, Atlanta, GA; and D. Eugene Strandness, M.D., professor of surgery, University of Washington School of Medicine, Seattle, WA. UMC faculty will join guest faculty in discussions on chronic heart failure, heart murmurs, diet and heart disease, phlebitis with and without pulmonary embolism, infections in cardiovascular patients, and noninvasive diagnosis of arterial and venous disease. Registration is limited to 150, and advance registration is required. Fee: \$100, Credit: 17 contact hours, 1.7 CEU, Category 1, AMA; AAFP.

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

FUTURE CALENDAR

Nov. 18, 1977

HEMOPHILIA SOCIETY MEETING

University Medical Center, Jackson

Dec. 3, 1977

COMMON HAND INJURIES

Mississippi Methodist Rehabilitation Center, Jackson

Mar. 9-10, 1978

SURGICAL FORUM V

Holiday Inn Downtown, Jackson

Mar. 30-April 1, 1978

GASTROENTEROLOGY UPDATE

Ramada Inn Coliseum, Jackson

DEATHS

HUGHES, WILLIAM L., Jackson. Born Raleigh, MS, July 25, 1903; M.D., University of Virginia School of Medicine, Charlottesville, 1926; interned University of Virginia Hospital, Charlottesville, one year; EENT residency, EENT Hospital, New Orleans, LA, 1927-28; died June 29, 1977, age 73.

JENKINS, WILLIAM N., Port Gibson. Born Wortham, TX, Sept. 9, 1895; M.D., Washington University School of Medicine, St. Louis, MO, 1920; interned Baptist Hospital, Memphis, TN, one year; died June 2, 1977, age 81.

KETY, SEIBERTH S., Picayune. Born Philadelphia, PA, Mar. 14, 1909; M.D., Louisiana State University School of Medicine, New Orleans, LA, 1937; interned Charity Hospital, New Orleans, one year; died July 1, 1977, age 68.

Dr. A. J. Wahba Is UMC Biochemistry Chairman

Dr. Albert J. Wahba has been named professor of biochemistry and chairman of the department at the University of Mississippi Medical Center.

UMC Vice Chancellor and School of Medicine dean Dr. Norman C. Nelson announced Dr. Wahba's appointment following approval of the Board of Trustees, Institutions of Higher Learning.

He succeeds Dr. Louis L. Sulya, who had been biochemistry professor and chairman of the department since the Medical Center opened.

Dr. Wahba, who joined the faculty Aug. 1, came to the Mississippi Medical Center from the University of Sherbrooke School of Medicine, Sherbrooke, Canada, where he has been professor of biochemistry

and director of the laboratory of molecular biology.

The new UMC department chairman earned the A.B. degree at the University of California, Berkeley, and the M.A. at the University of Texas, Austin. He received the Ph.D. from Tufts University School of Medicine, Boston.

Dr. Wahba was a fellow of the Damon Runyon Memorial Fund for Cancer Research at the National Institutes of Health, Bethesda, MD, 1956-1958; a Charlton Research Fellow at Tufts, 1959-1961; a fellow of the Jane Coffin Childs Fund for Medical Research at New York University School of Medicine, New York City, 1962; and a visiting scientist at the Salk Institute for Biological Studies in 1966.

He was on the faculty of NYU medical school from 1963-1969.

Author of or contributor to more than 60 scientific publications, Dr. Wahba's major research interest is molecular biology, specifically the synthesis of proteins from genetic material.

Medical Center Participates in Artery Bypass Study

Physicians at the University of Mississippi Medical Center are participating in an international investigation of a temporal artery bypass which shows promise in relieving ischemic brain disease.

Still in the developmental stages, the procedure is also believed to be effective in preventing major strokes.

Dr. Robert Smith, associate professor of neurosurgery, and co-investigator Dr. Armin Haerer, professor of neurology, will contribute 20 case histories this year to the study, supported by the National Institutes of Health. The new surgical procedure will be compared to conventional medical treatments.

The microsurgery requires a synthetic suture material half as thin as the finest human hair. The neurosurgeon re-routes a scalp vessel to the affected vessel inside the brain through a small trephine opening in the skull, thus supplying the deprived site with up to 100 cc's of blood per minute.

Dr. Smith points out that patients with carotid artery occlusion which cannot be managed with conventional surgical therapy, and those with stenosis of major intracranial arteries may benefit from the new bypass operation.

Dr. Guy Vise, Sr. Has Growing Bicentennial Project

Timber is nature's method of obtaining and storing solar energy and wood is stored solar energy that can be shipped anywhere and used in many ways,

according to Dr. Guy T. Vise, Sr., of Meridian.

The Vise family feels that trees are essential to our nation's survival. Dr. Vise had a special idea to commemorate his family's celebration of the U. S. bicentennial. In December 1976 he and his family planted 1776 loblolly pine trees to symbolize the beginning of the nation and to pay tribute to one of our greatest natural resources.

The Meridian physician's interest in growing trees began with his grandfather who was able to buy his first tract of land from the sale of hickory poles.

Dr. and Mrs. Vise's five children and their families all practice good forest management and have an interest in forestry.

Dr. Vise feels his forest lands led to a mutual family interest in land and timber and helped keep the family close.

Up until the bicentennial project, he felt the most rewarding work they'd accomplished was their timber stand improvement program. Now, all the Vises will watch the bicentennial crop growing.

Dr. Vise is a family practitioner and general surgeon. He has served as president of MSMA and on the Board of Trustees.

Medical Center Announces Faculty Changes

A new assistant professor of psychiatry has been named to the faculty at the University of Mississippi School of Medicine at the Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced the appointment and two faculty promotions following approval of the Board of Trustees, Institutions of Higher Learning.

New on the medical school faculty in the Department of Psychiatry and Human Behavior is Dr. Larry Durell Wade.

Promoted to professor of medicine in the medical school is Dr. Martin H. Steinberg, who is also assistant dean for coordination of research at the Veterans Administration Center.

Dr. Robert E. Lewis, Jr., moved up to assistant professor of anesthesiology, School of Medicine, and assistant professor of pathology, UMC.

Dr. Wade attended Mississippi State University and earned the M.D. degree at UMC in 1968. He did his internship at Lloyd Noland Foundation Hospital, Fairfield, AL, and his residency at Tulane University in New Orleans.

A Greenwood native, Dr. Wade has been a staff physician and staff psychiatrist at the Jackson Mental Health Center.

Mississippi Academy of Family Physicians Conducts Annual Meeting

Dr. Michael DeBakey of Houston, TX, was the opening speaker when the Mississippi Academy of Family Physicians met July 6-9 in Biloxi for the 29th Annual Scientific Assembly. Other out of state speakers were: Drs. Norman Kaplan of Southwestern University of Dallas; Irwin Zieper of Boston University; Robert P. Christopher of Memphis; Robert Irby of Richmond, VA; Rafael Sanchez of LA; Paulus Zee of Memphis; and Robert Hutchins of Johnson City, TN.

Physicians from Jackson participating on the program were: Drs. H. Davis Dear, Albert W. Conerly, James O. Manning, and Wallace V. Mann.

The three day meeting drew a record attendance of Mississippi and out of state physicians.

Dr. Norman Nelson, Chancellor of the University of Mississippi Medical Center, presented Mac Ernst with an award for the most outstanding junior medical student at UMC. The Mississippi Academy of Family Physicians' award to the most outstanding senior student was presented to Sidney Prosser by Dr. Walter Rose. The John B. Howell Memorial Award for outstanding contributions to family medicine was presented to Dr. James O. Stephens of Magee. A plaque of appreciation was also presented to David Wheat, student and president of the Family Practice Club, for his contribution to this club during the past year. Other awards included certificates of appreciation presented by Dr. W. R. Gillis of the Department of Family Medicine at UMC to over 55 Mississippi doctors who had served as preceptors for the Department of Family Medicine.

At the Hawaiian Luau on Friday evening, Dr. B. Leslie Huffman, president of the American Academy of Family Physicians, installed the following physicians as officers: president, Ralph L. Brock of McComb; president-elect, John M. Estess of Hollandale; vice-president, Edgar D. Johnson of Hattiesburg; secretary-treasurer, J. Edward Hill of Hol-

landale; delegate, Charles R. Jenkins of Laurel; alternate delegate, J. Edward Hill; directors, District 1, Louis Rubenstein of Ocean Springs; District 3, Elmo Gabbert of Meadville; District 5, William M. Gillespie of Meridian; District 7, Jerome B. Hirsch of Greenville; and District 9, Thomas S. Glasgow of Grenada.

Other directors serving another year of their two-year term are Drs. James C. Waites of Laurel; Hardy B. Woodbridge, Jr., of Jackson; James W. Allison of Vicksburg; John E. Powell of Houlika; and Malcolm Moore of Tupelo.

Dr. Ralph Brock, president, appointed Dr. Thomas Glasgow of Grenada chairman of the program for the 1978 session to be held July 12-15, 1978, at the Biloxi Hilton.

Plans Are Announced for MSMA's 110th Annual Session

MSMA's Council on Scientific Assembly met in August to begin planning for the association's 110th Annual Session to be conducted in Jackson, May 1-4, 1978, and selected the Ramada Inn Coliseum as the site for the meeting.

Thirteen scientific sections, the MSMA Auxiliary, numerous specialty societies and alumni groups are scheduled to meet during the 110th Annual Session of the association and the council has set aside Sunday afternoon, April 30, for a Seminar on the National Health Planning Act to be conducted by nationally recognized authorities. MSMA's House of Delegates will meet on Monday and Thursday mornings.

The Council on Scientific Assembly is composed of the chairmen and secretaries of the association's scientific sections. The secretary-treasurer of the association, Dr. J. Elmer Nix of Jackson, serves as chairman of the council.

ORGANIZATION / Continued

MMFES Will Issue Membership Materials

The Mississippi Medical Fraternal and Educational Society will distribute membership informational packets to all MSMA members in September describing the society's programs for medical professional liability coverage and aiming for a late October issuance of the Society's first membership certificates.

The board of the society recently met with representatives of its consulting firm, McNeary Insurance Consulting Services, Inc., to review membership materials dealing with coverage requirements and annual dues.

The society will offer three types of membership which are comparable in coverage to present types of professional liability insurance policies available in Mississippi and other states and competitive in cost. They are occurrence, modified claims made and claims made policies.

At the present time only the "claims made policy" is available to most Mississippi physicians. The claims made policy covers claims reported during the claims made policy period. When a physician drops his claims made policy coverage because of death, disability or retirement, he or his estate in case of death, has the option of purchasing a "reporting endorsement" to cover claims incurred but not reported during the claims made policy period.

The "modified claims made" membership the society will offer will cover the physician member upon retirement, disability or death without the necessity of purchasing a "reporting endorsement." Physicians who drop their modified claims made membership and continue in practice will not be covered for claims incurred but not reported unless they purchase a reporting endorsement.

The "occurrence type" membership the society will offer will be similar to the type of policy available to physicians in Mississippi prior to marketing of the claims made policy. The occurrence policy covers both claims reported and claims incurred but not reported during the occurrence policy period.

The board of the society has also acted to appoint membership and claims review committees. The membership committee, which will screen all applicants for membership in the society, is composed of both specialty and geographic representation.

The society's claims review committee will review all claims against members and oversee claims prevention programs.

The Mississippi Medical Fraternal and Educational Society was established by the MSMA Board of Trustees and House of Delegates in 1975 after study revealed a declining market for physicians' professional liability insurance coverage and growing dissatisfaction among Mississippi physicians over the type of coverage available.

The Board of Directors is composed of the following physicians who are subject to election by the society's membership: R. Faser Triplett, M.D., Jackson, president; William C. Gates, M.D., Columbus; Walter H. Rose, M.D., Indianola; Max L. Pharr, M.D., Jackson; Richard C. Miller, M.D., Jackson; Thomas D. Little, M.D., Meridian; Andrew K. Martinolich, Jr., M.D., Bay St. Louis; Louis C. Lehmann, M.D., Natchez; and Gerald P. Gable, M.D., Hattiesburg.

Dr. Lee Reid Retires From Board of Health

Dr. Lee R. Reid retired recently from the Mississippi State Board of Health after providing 32 years of service to Mississippians.

Dr. Reid, who was born in Helena, AK, attended Millsaps College and received his medical degree from the University of Pennsylvania. He returned to Mississippi in 1945 to serve as chief surgeon at the Mississippi State Sanatorium from 1945 to 1952. He then began full-time private practice in Jackson in diseases of the chest and thoracic surgery.

In 1952, he joined the Tuberculosis Control Unit on a part-time basis as a consultant on diseases of the chest. After giving up his private practice in 1965, he became a full-time consultant in Tuberculosis Control.

According to Dr. Reid, when he first began practicing medicine, tuberculosis was still one of the leading causes of death in this country. However, during his years with the Sanatorium and since then at the State Board of Health, great progress has been made in tuberculosis control.

"While I was serving as chief surgeon at the Sanatorium, we tried to control tuberculosis with bed rest and/or surgery," said Dr. Reid. "At that time a patient in the Sanatorium might have had to spend from two to four years in bed. Surgical procedures then usually consisted of removing the ribs. The process of putting air in the chest to collapse the lung so that it might rest more was widely used.

"Then in 1952 the powerful drug INH (isoniazid) was discovered which made the control of TB much easier," continued Dr. Reid. "With the help of this drug and several others which have been added since

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tolbutamide, U.S.P., Upjohn

0.5 Gm tablets



*"In a real dark night of the soul
it is always three o'clock in the morning."*

—F. SCOTT FITZGERALD
THE CRACKUP, 1936



Insomnia

a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime.¹ Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO. Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information

ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

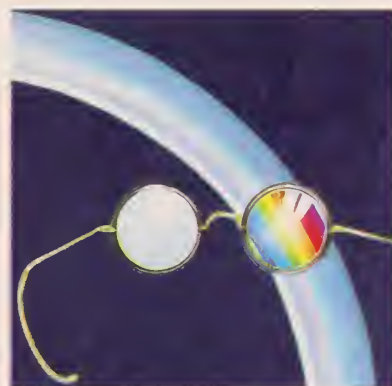
Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response.

Usual optimum daily dosage is 75 mg to 150 mg per day, not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg and 50 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR

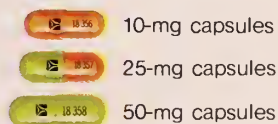


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in all its colors.

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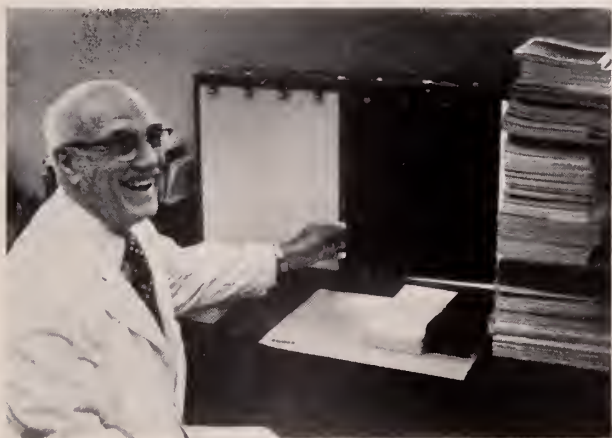
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then, the disease can be controlled within a matter of months. Now those long periods of bed rest are no longer necessary. A patient can even go back to work after a few weeks if his condition is such that he cannot transmit the disease.

"TB is not nearly as prevalent now as it used to be," added Dr. Reid. "Twenty years ago we were seeing between 800 and 1,000 new cases of tuberculosis in the state each year. Now we only have about 400 new cases a year. Things have definitely changed for the best."

According to Dr. Reid, now that the Sanatorium is no longer functioning, the responsibility of the local health departments has increased. About 90 per cent of the tuberculosis cases in the state are treated through the county health departments. Each health department has been sending its chest x-rays to Dr. Reid, who has been interpreting them and sending back the diagnosis since 1952.

Dr. Reid also made periodic visits to the county health departments to discuss problem cases every three months and traveled to seven regional hospitals in the state to hold chest conferences as a consultant.



Dr. Reid is shown at his desk in the State Board of Health headquarters.

MSMA Board Holds Summer Meeting

MSMA's Board of Trustees held its regular summer meeting in Columbus Aug. 18-19. Primary business coming before the Board were referrals from the annual session of the House of Delegates, reports on organization of the Mississippi Medical Fraternal and Educational Society and other ongoing association activities and review and discussion of the Mississippi Health Systems Plan.

Based on action of the House of Delegates at the 109th Annual Session, the Board will study and make a recommendation to the House concerning association endorsement of Blue Cross-Blue Shield of Mississippi. The Board considered past association policy in this regard and directed a series of questions for consideration by Blue Cross-Blue Shield and further reporting at the Board's December meeting.

The Board received a report on organizational plans of the Mississippi Medical Fraternal and Educational Society from Dr. Fraser Triplett, president of the society, and Mr. William Moore, president, McNeary Insurance Consulting Services, Inc., of Charlotte, N. C. The society is moving toward an October 1977 goal for issuing its first membership certificates.

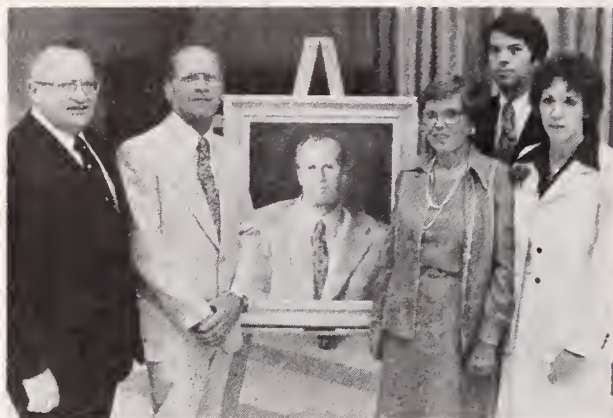
MSMA's delegates to the AMA, Dr. G. Swink Hicks and Joseph B. Rogers, reported to the Board on the recent June meeting of the AMA House of Delegates particularly noting in this regard that efforts to equalize Medicare fees between areas of the country as sought by Mississippi had increased although the AMA House of Delegates still wanted more study on this proposition. Such states as Kentucky and Illinois had now joined Georgia and Mississippi in this effort.

The Council on Scientific Assembly reported to the Board through its chairman, Dr. J. Elmer Nix, that planning for the 110th Annual Session of the association was proceeding. The council has selected the Coliseum Ramada Inn in Jackson as the site for the meeting and a special program on the National Health Planning and Resources Development Act (Public Law 93-641) is being scheduled.

A representative of the Mississippi Health Systems Agency, Inc., met with the Board to discuss the Mississippi Health Systems Plan developed by that organization. The plan is required by Public Law 93-641 and its purpose is to project goals for improving health care and meeting health needs in the state.

The Board also received a report on the status of legal matters involving the association and acted to approve additional funding for the MSMA Auxiliary's publication "Distaff," reviewed the association's mid year fiscal status and received a membership report showing over 1600 MSMA members, a new high; authorized co-sponsorship with the Mississippi Hospital Association of a Leadership Seminar titled "Health Care Update" on September 16, 1977, in Jackson; and authorized association sponsorship of a "Practice Management Workshop" for members of the Mississippi Association of Medical Assistants in Jackson this year.

Dr. L. Sulya Retires From UMC



University of Mississippi Medical Center biochemistry chairman Dr. Louis Sulya ended his 32-year association with the University on June 30. Colleagues unveiled a Karl Wolfe portrait of Dr. Sulya during a luncheon in his honor attended by UMC vice chancellor Dr. Norman C. Nelson (left), Mrs. Sulya, and Dr. Sulya's daughter and son-in-law, Mr. and Mrs. Austin Bunch. Dr. Sulya joined the biochemistry department on the Oxford campus in 1945 as associate professor and became chairman of the department in 1950. He became a member of the School of Medicine admissions committee in 1950 and its chairman in 1965.

FP Preceptors Attend UMC Workshop



Over 130 Mississippi family physicians teach University of Mississippi School of Medicine juniors and seniors about family practice at the local level. Among preceptors attending a one-day workshop in Jackson on the UMC program designed to give medical students an indepth view of the life and practice of the community doctor were, from left, Dr. Grayden Tubb of Fulton, Dr. Edmond Whitfield of Florence, Dr. Edward North, Jr., of Jackson, and Dr. James E. Warrington of Shelby.

Newborn Art Contest Winners Are Announced



Frances Melton of Durant, right, took first place honors in the second annual University of Mississippi Medical Center Newborn Center art competition. Mrs. Melton's watercolor, "Motherhood," was among 48 entries in the UMC March of Dimes-sponsored contest, which is designed to create a greater awareness of the need to improve state maternal and infant care. Dr. John E. Rawson, left, UMC associate professor of pediatrics, is director of the Newborn Center. The \$250 prize given to the adult division winner was sponsored by Unifirst Federal Savings and Loan Association. Rowena Houston of Belzoni, a student at Delta State University, was the "college and university purchase award" winner for her lava carving "Mother and Child."

Southeastern Internists Meet in October

Specialists in internal medicine and related medical fields from Alabama, Georgia, Louisiana, Mississippi and South Carolina will take part in a two-day scientific meeting in Jackson, MS, Oct. 7-8.

Physicians who attend the regional meeting are eligible for credit toward the American Medical Association Physician's Recognition Award in Category 1.

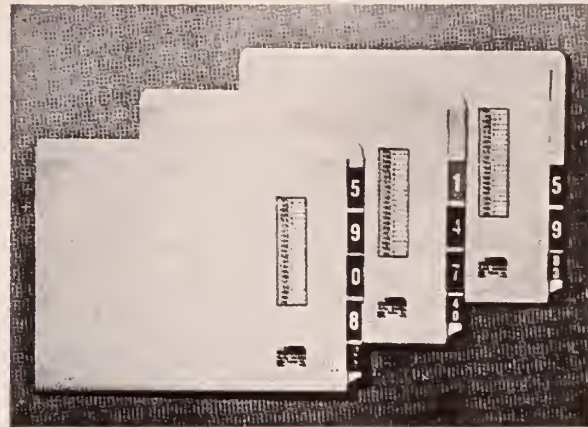
In charge of planning for the ACP's Southeastern

Regional Meeting is Thomas M. Blake, M.D., F.A.C.P., Jackson, who serves as the medical specialty society's representative in the area.

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IN CONCLUSION

There's no clear evidence of a link between oral contraceptive use and cancer after 17 years of study, according to a report from George Washington U. Medical Center researchers published in Population Reports. Report said users of the contraceptives seem less likely to develop benign breast tumors and more likely to develop benign liver tumors, and notes that a lack of knowledge of the development of various types of tumors and their relationships to hormones makes it difficult to predict the results of such research.

The AMA Department of Mental Health will soon begin publication of a newsletter on various aspects of the impaired physician problem. Featured will be reports on state medical association programs, as well as information about legislation, treatment techniques and facilities, licensing board activities, auxiliary activities and specialty society and hospital programs. The new publication will be sent free of charge to those requesting it from Department of Mental Health, AMA, 535 North Dearborn Street, Chicago, IL 60610.

More than 40 per cent of U.S. births may be unwanted or mistimed, according to a report in Family Planning Perspectives. Report said fertility remains significantly higher among the poor, the young, and the unmarried. Differences in fertility rates appear to be associated with differentials in contraceptive use, suggesting "the continued need for publicly funded programs that seek to prevent unplanned childbearing among couples who might be deprived of effective contraceptive services for economic and other reasons."

Governor Cliff Finch has recently signed a comprehensive drug bill making Mississippi the first state in the South and the eighth in the nation to decriminalize minor marihuana offenses. New law eliminates arrest and jail for first time possession of up to one ounce of marihuana. Violators will be given a traffic ticket-like citation and will face a \$100-250 civil fine. Penalties increase with each additional offense. Altogether, marihuana decriminalization proposals are being considered by 35 states and Congress.

In the four months since it was created by HEW reorganization, the Health Care Financing Administration (HCFA) has managed to build an elaborate bureaucracy, with duplicate and overlapping services, according to a Government Accounting Office study. This description came out at hearings of the Senate Finance Committee's health subcommittee. The session was called to hear the results of the GAO evaluation of HCFA, the new parent organization of Medicare, Medicaid and other social services -- an evaluation requested by Chairman Talmadge.

For recurrent attacks of urinary tract infection in women

BactrimTM DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose[®] packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose[®] packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

October 1977

BALCONY

Journal of the
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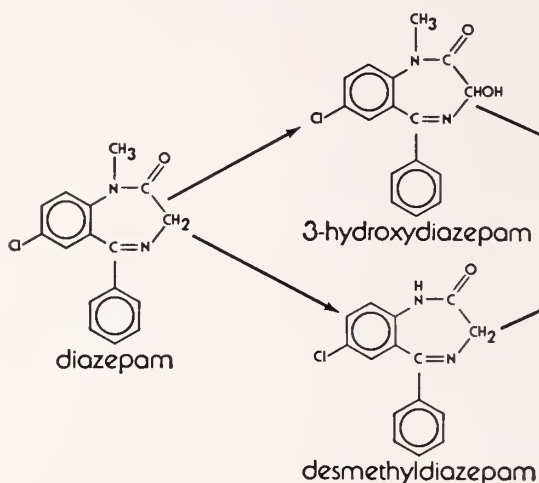
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a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Laetrile Causes Cyanide Poisoning

Death of an 11-year-old girl from accidentally swallowing laetrile tablets was reported in the Aug. 8 *Journal of the American Medical Association*.

A trio of Buffalo, NY, physicians report that the child swallowed from one to five tablets of the product. It belonged to her father, who has cancer. The tablets were thought to be harmless by the parents and were contained in a vial along with an assortment of vitamin tablets, the doctors say.

The child became listless within half an hour after swallowing the tablets, and vomited. When breathing became difficult and the child began to lose consciousness, the mother rushed her to a hospital, extensive and heroic treatment measures were instituted, but the child died after 72 hours.

Death was from cyanide poisoning. Laetrile is made from the pits of apricots, which contain cyanide.

Seminars on National Health Insurance Are Set

Seminars to alert physicians to what proposed national health insurance could mean to them and to their patients will be held in 37 American cities, including Jackson, MS, during October.

Physicians from England, Canada, and Australia will join American journalists, legislators and physicians in the evening seminars to which physicians, medical students, their spouses and guests are invited.

Sponsors of the seminars include the Congress of County Medical Societies based in Oklahoma City. Dr. Francis A. Davis, president of the congress, says the purpose of the seminars is to help physicians educate their patients to what national health insurance would mean to the quality of medical care the patients now enjoy.

The Jackson Seminar is set for 7 p.m. on Oct. 13 at the Medical Center Holiday Inn. No admission will be charged.

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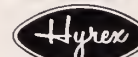
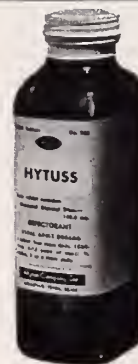
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Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** Adults—1 tablet four times daily. Children—6 to 12 years of age; ½ tablet 3 or 4 times daily. **HOW SUPPLIED:** White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.



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Volume XVIII

Number 10

October 1977



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (Publication No. 284800) is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$15.00 per annum; \$2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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Blue Cross Seeks Cost Controls

A mandatory cost containment program for its members has been announced by the national Blue Cross Association as a step to control hospital costs which have been increasing by 15 per cent a year.

Blue Cross Plans will now be required to have:

- Active fraud and abuse investigation programs.
- An internal claims screening program for determining medical necessity and appropriateness of hospital stays.
- Periodic exploration of incentive approaches for paying participating hospitals.
- Educational programs stressing proper use of health care services.
- Active programs to verify subscriber eligibility for services and to eliminate duplicate payments for the same service.

Blue Cross noted that some or all of its cost containment program was operating in several plans now resulting in savings to subscribers. Blue Cross also suggests that its member plans try optional activities to control health costs such as home care, ambulatory/same day surgery, second opinion surgery and preadmission testing.

The Push for NHI Begins

The Carter Administration will begin what many believe will be its initial push for national health insurance with a series of public hearings to be conducted in every state beginning in October.

Secretary of H.E.W. Califano, when asked the "reasoning" behind holding the hearings in light of the hundreds of such hearings over the past few years stated that "no one has ever passed the national health insurance plan. I am trying to figure out a plan that we can pass."

As JOURNAL MSMA went to press, Dr. James Mongan, a Senate Finance Committee staffer, was expected to be named as assistant secretary for national health insurance. Mongan is a colleague of Jay Constantine, chief professional staff member for health on the Senate Finance Committee who has visited Mississippi on occasion to discuss the PSRO program.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)

ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 $\mu\text{g/ml}$) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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Choledyl® (oxtriphylline) Tablets and Elixir CAUTION: Federal law prohibits dispensing without prescription. Each partially enteric coated tablet contains 200 mg or 100 mg oxtriphylline. Each teaspoonful of the elixir contains 100 mg oxtriphylline; alcohol 20%. **Indications.** Choledyl (oxtriphylline) is indicated for relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema. **Warning.** Use in pregnancy — animal studies revealed no evidence of teratogenic potential. Safety in human pregnancy has not been established; use during lactation or in patients who are or who may become pregnant requires that the potential benefits of the drug be weighed against its possible hazards to the mother and child. **Precautions.** Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children. **Adverse Reactions.** Gastric distress and, occasionally, palpitation and CNS stimulation have been reported. **Dosage.** Average adult dosage: Tablets — 200 mg, 4 times a day; Elixir — two teaspoonfuls, 4 times a day. **Supplied.** 200 mg yellow, partially enteric coated tablets in bottles of 100 (N 0047-0211-51) and 1000 (N 0047-0211-60); Unit Dose — 200 mg tablets (N 0047-0211-11); 100 mg red, partially-enteric coated tablets in bottles of 100 (N 0047-0210-51). Elixir — bottles of 16 fl oz (1 pint) 474 ml (N 0047-0215-16). **Toxicity.** Oxtriphylline, aminophylline and caffeine appear to be more toxic to newborn than to adult rats. No teratogenic effects have been seen. Full information is available on request.

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Champus Urges Increased Fees

Dr. Robert N. Smith, Assistant Secretary of Health for the Department of Defense, has urged Congress to raise CHAMPUS reimbursement rates to physicians from the 75th percentile to the 90th percentile of prevailing fees.

In a recent appearance before the House Armed Services Committee, Dr. Smith cited declining physician participation in the program and increasing need for health services from private physicians because of serious military physician and specialist shortage as reasons for the proposed increase back to the old CHAMPUS reimbursement level.

CHAMPUS is also now experiencing delays in claims processing due to a decision last year to move to new regional fiscal administrators. Mississippi, which was a single state contractor, is now combined with Louisiana and in other areas of the country as many as 3-5 states are combined.

Appropriations for the CHAMPUS program are authorized by the House and Senate Armed Services Committees and Congressman G. V. Montgomery and Senator John C. Stennis of Mississippi serve on the committees, the latter as chairman of the Senate committee.

Influenza Virus Vaccine For 1977-78 Is Listed

Bivalent influenza vaccine for 1977-78 will contain in each adult dose 200 CCA units of influenza A virus comparable to the prototype A/Victoria/3/75 (H3N2) and 200 CCA units of B/Hong Kong/5/72 influenza virus, according to the State Board of Health.

The vaccine will be available in "split-virus" and "whole-virus" preparations. Adults and older children, most of whom had experience with influenza antigens related to A/Victoria/3/75 or B/Hong Kong/5/72 either by infection or through vaccination, can be expected to have a good antibody response to a single dose of the 1977-78 bivalent influenza vaccine. Children less than six years of age, some of whom have not encountered the currently prevalent viruses, will need two doses of vaccine given four or more weeks apart in order to achieve satisfactory antibody responses. These children may not be adequately protected unless the second dose is given. Furthermore, because children and adolescents tend to experience somewhat more side effects from influenza vaccine than adults, split-virus vac-

cines may be more acceptable for persons less than 18 years of age.

Annual vaccination is recommended for adults and children of all ages who have such chronic conditions as: 1) heart disease of any etiology, particularly with mitral stenosis or cardiac insufficiency; 2) chronic bronchopulmonary diseases, such as chronic bronchitis, bronchiectasis, tuberculosis, emphysema, and cystic fibrosis; 3) chronic renal disease; and, 4) diabetes mellitus and other chronic metabolic disorders.

Vaccination is also recommended for older persons, particularly those over age 65 years, because excess mortality in influenza outbreaks occurs in this age group.

Essential service businesses and industries may wish to have their medical departments arrange to offer vaccination to their employees.

As in past years, the State Board of Health will offer vaccination to persons in nursing homes and to all patients enrolled in the chronic illness programs operated by the health departments. Vaccine is not offered to the general public nor can health departments undertake responsibility for industrial vaccination programs.

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1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose. Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg. per ml.

NEWSLETTER

October 1977

Dear Doctor:

In an effort to counter what many view as an "alarming" increase in births at home, five leading medical organizations have endorsed sweeping changes in the way hospitals handle births. The Interprofessional Task Force on the Health Care of Women and Children announced its recommendations at the American College of Ob and Gyn annual meeting. A nationwide program would be undertaken to persuade every U.S. hospital to offer liberalized programs as part of the birth process.

Proposals include having fathers present in the delivery room and letting young children visit their mothers and new brothers and sisters. The home birth movement is seen by many physicians as a protest against cold, impersonal surroundings offered by some hospitals; the public wants more control.

AMA's Education and Research Foundation will administer a \$765,765 grant from the W. K. Kellogg Foundation to the National Joint Practice Commission. Grant will be used to underwrite a demonstration of how to establish joint or collaborative physician-nurse practice in hospitals. Four U.S. hospitals of different size and type will participate and 60 other hospitals will observe the demonstration.

Although the pill remains the most popular method of contraception among young married women, sterilization is now the method of choice among couples married a decade or more, as well as among couples who have had all the children they want, according to Family Planning Perspectives. Three-quarters of couples using contraception now use the most effective: pill, sterilization or IUD.

The physician's role in preventing malpractice claims extends beyond his medical competence and his personal relationship with patients, according to St. Paul's Malpractice Digest. Some 16 per cent of 1975-76 claims charged malpractice in services provided in a doctor's office. Appearance and management efficiency, level of knowledge and personal understanding by office staff were cited.

Minimum funding level of all HSAs has been raised to \$175,000 regardless of the size of the population served. Bureau of Health Planning and Development based its action on the assumption that health planning agencies established under the National Health Planning and Resources Development Act of 1974 will be assuming more functions and will require increased support.

Sincerely,



Nola Gibson
Managing Editor

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For additional information contact: John R. Reedy,
Executive Director.

Riverside Hospital

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Telephone: (601) 939-9030



DATELINE

Health Programs Are Extended

Washington, DC - A one-year extension of several health programs with only a few major changes as incorporated in HR 4975 -- Funds for Expiring Health Programs -- has been agreed upon by a House-Senate conference committee. Among programs given simple one-year extension of authority through fiscal year 1978 are health planning, home health services, community mental health centers, maternal and child health services, community health services, and family planning.

Alcoholism Manual Is Updated by AMA

Chicago, IL - Real progress is being made in mobilizing the nation to deal with alcoholism, states the newly revised Manual on Alcoholism of the AMA. Physicians recognize that all patients (including alcoholics) are sick persons whose total conditions have many aspects and broad ramifications, according to the manual. Intensive treatment centers for alcoholic patients are being founded and more and more general hospitals are admitting alcoholics under their correct diagnoses.

Epilepsy Commission Releases Report

Bethesda, MD - A report of the Commission for the Control of Epilepsy and Its Consequences indicates that there are more than $\frac{1}{4}$ million persons with epilepsy in the U.S. whose seizures are inadequately medicated; yet, many of them could be seizure free with new medications and the proper delivery of services. At least one million seizures could be prevented each year with a saving to this country of some \$900,000, according to the report which contains over 400 specific recommendations for action.

Pets May be Related to Multiple Sclerosis

Chicago, IL - There appears to be a relationship between prolonged and close contact with house pets and the subsequent development of multiple sclerosis, according to a recent issue of JAMA. Dr. S. Jotkowitz of Hackensack, NJ, reported on a study of 50 multiple sclerosis patients. Forty-six (92 per cent) had close contact with a house pet prior to onset of illness. Several patients reported their dogs had distemper within several years of their own onset of illness.

Radiology Manpower Survey Is Updated

Chicago, IL - "At the present time, we have, without regulation, achieved a rather amazing equilibrium between needs and available personnel," reports the updated report of the 1975 Task Force on Manpower and Facilities of the American College of Radiology. Some 4,000 questionnaires were sent to radiologists who have been certified from 1972-75. This latest survey showed that in 1975 there were about 14,500 radiologists in practice; now the yearly increase is approximately 700.

Mississippi Reportable Diseases For 1977 Are Listed

Diseases which should be reported to the Mississippi State Board of Health are listed below. Reports may be submitted by physicians, nurses (office, hospital, school or other), medical record librarians, hospital administrators, school principals, or others. Reports may be telephoned or mailed to the county health department or the Bureau of Disease Control, Mississippi State Board of Health (phone 354-6650). Special report cards are available from the Bureau of Disease Control. Mississippi state regulations support these reporting procedures.

Group I. The following diseases should be reported by telephone to the State Board of Health immediately: botulism, cholera, plague, poliomyelitis, smallpox, yellow fever.

Group II. The following diseases should be reported by telephone to the Local Health Department or the State Board of Health within 24 hours: anthrax, diphtheria, dengue, encephalitis (primary), encephalitis (post infectious), food poisoning (all types except botulism which is in Group I), gonococcal infections, measles (Rubeola), meningitis, meningococcal, meningococcemia, rabies, rubella

(including congenital rubella syndrome), syphilis, typhoid fever, typhus (epidemic).

Group III. The following diseases should be reported to the Local Health Department or State Board of Health through routine reporting methods unless unusual circumstances suggest they should be reported more rapidly: amebiasis, ancylostomiasis (hookworm), blastomycosis, brucellosis, chancroid, coccidioidomycosis, cryptococcosis, giardiasis, granuloma inguinale, heavy metal poisoning (arsenic, lead, mercury and others), helminthic diseases not otherwise listed (specify), hepatitis—A (infectious), hepatitis—B (serum), hepatitis (other, specify), histoplasmosis, hydatidosis (echinococcosis), leprosy, leptospirosis, lymphogranuloma venereum, malaria, meningitis (bacterial, specify), meningitis (viral or aseptic), mononucleosis (infectious), mumps, mycoses (systemic, not otherwise listed, specify), occupational diseases (poisoning, pneumoconiosis, dermatitis, radiation), pertussis, pesticide poisoning, psittacosis (ornithosis), Q fever, relapsing fever, rheumatic fever, Rocky Mountain Spotted Fever, salmonellosis, shigellosis, sporotrichosis, tetanus, toxoplasmosis, trichinosis, tuberculosis, tularemia, typhus fever (endemic or murine).

Group IV. The following diseases should be reported to the Local Health Department or the State Board of Health weekly, listing only the number of cases seen: ascariasis, chickenpox, gastroenteritis, influenza, pediculosis (specify), streptococcal pharyngitis.

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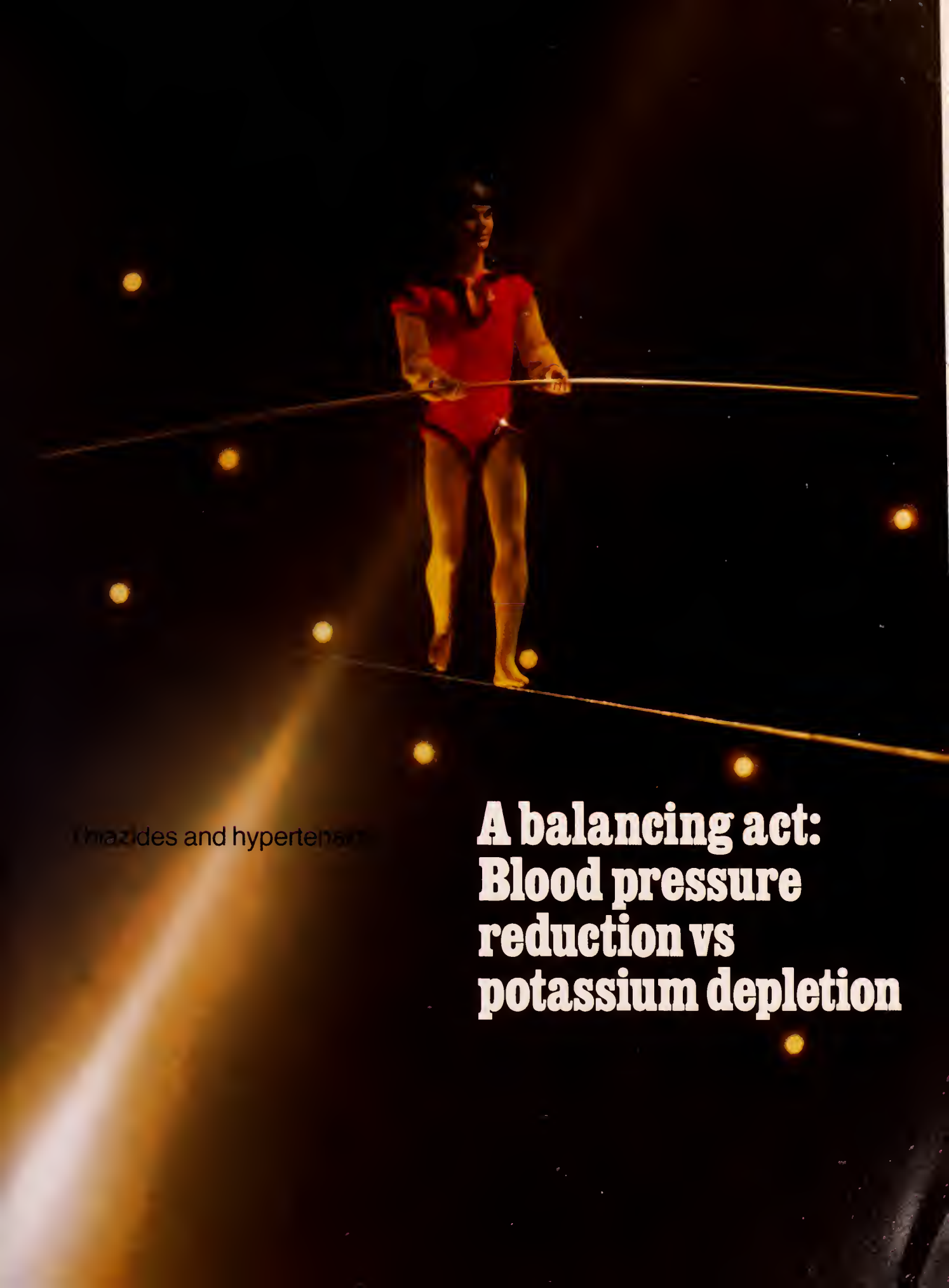
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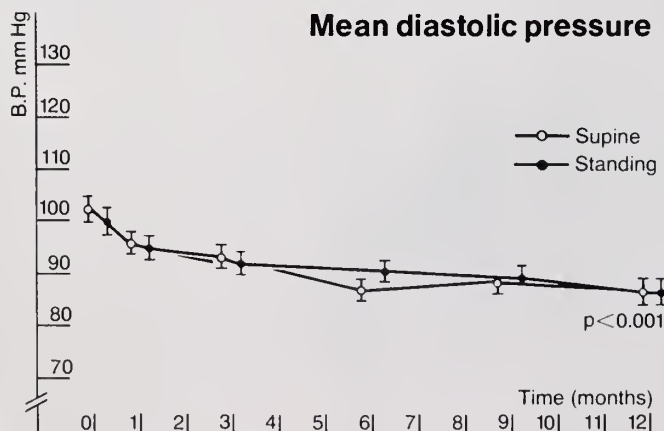
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"The patients were receiving a single daily dose of 10 mg bendrofluazide [bendroflumethiazide]...there were no apparent side effects from the medication."

*Wilkinson PR et al: The Lancet 1:759-762, 1975.



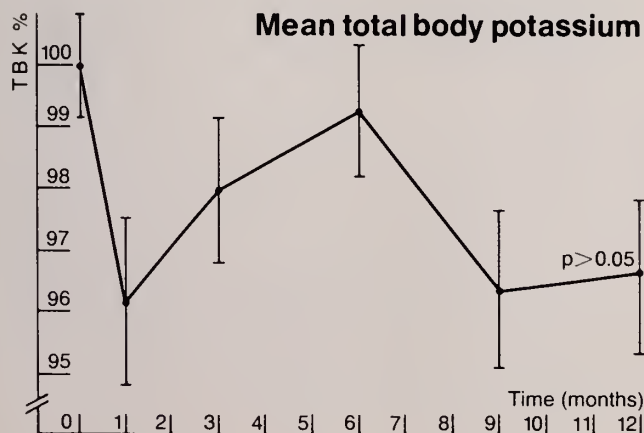
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Potassium stabilized at 96% mean TBK



"The amount of potassium loss during the period of study did not seem to be clinically significant."

"A serum potassium of less than 3.5mmol per litre is often taken as the value below which potassium supplements should be given...At an arbitrary lower value for serum potassium of 3.0mmol per litre, few patients, our data suggest, would need potassium supplements. Our findings with TBK support this view..."

See next page for full prescribing information.

Once a day Naturetin® Bendroflumethiazide Tablets N.F.

NATURETIN®-2.5

NATURETIN®-5

NATURETIN®-10

Bendroflumethiazide Tablets N.F.

DESCRIPTION

Naturetin (Bendroflumethiazide Tablets N.F.) is a benzothiadiazine derivative containing a benzyl and a trifluoromethyl group. It is a potent oral diuretic and antihypertensive agent available as compressed tablets providing 2.5, 5.0, or 10 mg. bendroflumethiazide.

ACTIONS

The mechanism of action results in an interference with the renal tubular mechanism of electrolyte reabsorption. At maximal therapeutic dosage all thiazides are approximately equal in their diuretic potency. The mechanism whereby thiazides function in the control of hypertension is unknown.

INDICATIONS

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated as adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis and corticosteroid and estrogen therapy.

Bendroflumethiazide has also been found useful in edema due to various forms of renal dysfunction such as: nephrotic syndrome, acute glomerulonephritis, and chronic renal failure.

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated in the management of hypertension either as the sole therapeutic agent or to enhance the effectiveness of other antihypertensive drugs in the more severe forms of hypertension.

Usage in Pregnancy. The routine use of diuretics in an otherwise healthy woman is inappropriate and exposes mother and fetus to unnecessary hazard. Diuretics do not prevent development of toxemia of pregnancy, and there is no satisfactory evidence that they are useful in the treatment of developed toxemia.

Edema during pregnancy may arise from pathological causes or from the physiologic and mechanical consequences of pregnancy. Thiazides are indicated in pregnancy when edema is due to pathologic causes, just as they are in the absence of pregnancy (see WARNINGS). Dependent edema in pregnancy, resulting from restriction of venous return by the expanded uterus, is properly treated through elevation of the lower extremities and use of support hose; use of diuretics to lower intravascular volume in this case is illogical and unnecessary. There is hypervolemia during normal pregnancy which is harmful to neither the fetus nor the mother (in the absence of cardiovascular disease), but which is associated with edema, including generalized edema, in the majority of pregnant women. If this edema produces discomfort, increased recumbency will often provide relief. In rare instances, this edema may cause extreme discomfort which is not relieved by rest. In these cases, a short course of diuretics may provide relief and may be appropriate.

CONTRAINDICATIONS

Bendroflumethiazide is contraindicated in anuria.

It is also contraindicated in patients who have previously demonstrated hypersensitivity to it or other sulfonamide-derived drugs.

WARNINGS

Bendroflumethiazide should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may be additive or may potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers. Thiazides appear in breast milk. If use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS

Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: dryness of the mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes mellitus may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS

Gastrointestinal System: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), and pancreatitis.

Central Nervous System: dizziness, vertigo, paresthesia, headache, and xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, and aplastic anemia.

Dermatologic-Hypersensitivity: purpura, photosensitivity, rash, urticaria, and necrotizing angitis (vasculitis, cutaneous vasculitis).

Cardiovascular: orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics. **Other:** hyperglycemia, glycosuria, occasional metabolic acidosis in diabetic patients, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, and restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSAGE AND ADMINISTRATION

Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

Diuretic: The usual dose is 5 mg. once daily, preferably given in the morning. To initiate therapy, doses up to 20 mg. may be given once daily or divided into two doses. A single daily dose of 2.5 to 5 mg. should suffice for maintenance.

Alternatively, intermittent therapy may be advantageous in many patients. By administering the preparation every other day or on a three to five day per week schedule, electrolyte imbalance is less likely to occur; however, the possibility still exists.

In general, the lowest dosage that achieves the therapeutic response should be employed.

Antihypertensive: The suggested initial dosage is 5 to 20 mg. daily. Maintenance dosage may range from 2.5 to 15 mg. per day, depending on the individual response of the patient. When the diuretic is used with other antihypertensive agents, lower maintenance doses for each drug are usually sufficient.

STORAGE

Store at room temperature; avoid excessive heat.

HOW SUPPLIED

2.5 mg. tablets in bottles of 100, 5 mg. tablets (scored) in bottles of 100 and 1000, and 10 mg. tablets (scored) in bottles of 100.

SQUIBB®

Causes of Perinatal Death Are Studied

The U. S. infant mortality rate—regarded as one indicator of the health of the U. S. population—has been improving steadily since World War II.

In 1975 infant mortality rate was 16.1 per 1,000 live births. This represents a 44.9 per cent decrease from 1950, when the rate was 29.2.

But medical science is far from satisfied with the gains, and research continues on many fronts to try for even lower rates.

One such study—seeking to catalog the causes of deaths between 20 weeks of gestation and 28 days after birth—was reported in the July 18 *Journal of the American Medical Association* by Richard L. Naeye, M.D., of Pennsylvania State University College of Medicine, Hershey. Dr. Naeye reports findings of the Collaborative Perinatal Project organized by the National Institute of Neurological and Communicative Disorders and Stroke.

The study sought to identify underlying causes of death in 53,518 pregnancies in the United States, in 12 university-affiliated hospitals in different regions between 1959 and 1966. Autopsies were performed on some of the infants, and placental examinations on some two-thirds.

The leading cause of death (17 per cent) was acute amniotic fluid infection, causing pneumonia in the unborn or newborn, says Dr. Naeye. Second leading cause (11 per cent) was premature detachment of the placenta prior to birth. Premature rupture of the membrane caused 10 per cent of the deaths, and 9 per cent were attributed to inherited defects. A variety of causes were assigned in the others.

Three-fourths of the deaths were due to disorders that at present are so poorly understood that it is not clear how they can be prevented, he points out.

The trend of decreasing deaths is certain to continue "if we learn more about the pathogenesis of the pertinent disorders and develop specific means to prevent them."

Jackson Will Host Hemophilia Workshop

A Hemophilia Symposium and Demonstration Workshop will be held Nov. 18 at the Downtowner Motor Inn in Jackson.

The program will be sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education and the School of Nursing, Mississippi Health Systems Agency, Inc.,

the National Hemophilia Foundation and the Greater Mississippi Area Chapter of the National Hemophilia Foundation. Cutter Laboratories and Hyland Laboratories are supporting the program through postgraduate educational grants.

Advance registration is requested and the \$10.00 registration fee will cover parking, luncheon and program.

Seven hours of continuing education credit will be given by AMA (Category 1), AAFP and MNA.

The objectives of this workshop are: (1) to present new information to health professionals about the diagnosis, treatment, complications, genetics and psychological implications of hemophilia; (2) to inform health professionals of the referral services and consultants available; (3) to inform health professionals of the physicians' needs for administering quality care to their hemophilia patients; and (4) to recruit health professionals to work directly with persons with hemophilia in this area.

Faculty will include professors from UMC and professionals from the Mississippi chapter and National Hemophilia Foundation.

For advance registration write Barbara Dinsmore, Executive Director, Greater Mississippi Area Chapter, NHF, P.O. Box 22667, Jackson, MS 39205.

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Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); and 25 mg phenobarbital in the immediate release layer.

Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

See next page for brief summary.

SUSTAINED ACTION



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CAUTION: Federal law prohibits dispensing Tedral SA without prescription.

Description. Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Tedral SA: each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital in the immediate release layer.

Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

Tedral Elixir is convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients; porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to *one-quarter* Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

STORE BETWEEN 59° and 86°F (15° and 30°C).

Full information is available on request.

UMC Makes Neurology A Separate Department

The division of neurology in the Department of Medicine at the University of Mississippi School of Medicine has been elevated to department status with Dr. Robert Currier, chief of the division, as chairman.

Dr. Norman C. Nelson, Medical Center vice chancellor and School of Medicine dean, announced the establishment of the new medical school department following approval of the Board of Trustees, Institutions of Higher Learning.

About 80 per cent of the medical schools in the United States, Dr. Nelson says, now have separate neurology departments.

"In the 16 years since the division of neurology was established, medical school enrollment has increased 111 per cent from 282 in 1961 to 596 in 1977-78 and the faculty has grown from two to 14," Dr. Nelson said. "The faculty has published more than 130 scientific papers and books and has attracted \$1,250,000 in federal grants to support research during this period."

Dr. Currier joined the UMC faculty in 1961 as associate professor of medicine (neurology) and chief of the neurology division.

Medical Center Hosts Stokes Memorial Visiting Professor

A professor of pharmacology at the Medical College of Wisconsin was the first Stokes Memorial Visiting Professor at the University of Mississippi Medical Center. Dr. Edward J. Cafruny was a lecturer in the UMC Department of Pharmacology and Toxicology during September.

The Mississippi medical school class of 1960 established the new guest lecturer program at the Medical Center as a memorial to the late Dr. Jack Avery Stokes of Pontotoc.

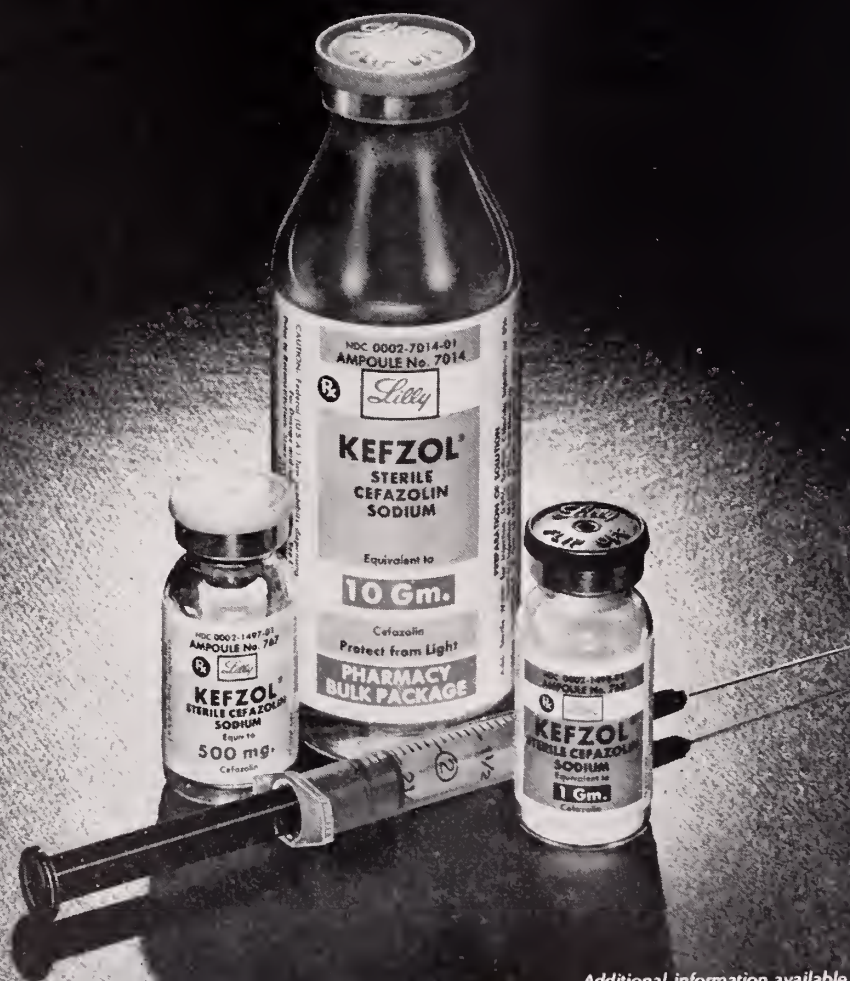
The professorship will rotate through the medical school departments on an annual basis.

Dr. Stokes was a family physician in Pontotoc at the time of his death in June, 1974. He earned the B.S. degree at Ole Miss in 1957 and the M.D. at the Medical Center in 1960. He did his internship at University Hospital and entered private practice in Pontotoc.

Dr. William J. Gillespie of Jackson is chairman of the Stokes Memorial Visiting Professorship committee for the UMC class of 1960. Other members are Dr. Dewitt Grey Crawford of Louisville, Dr. John Y. Gibson of Jackson, and Dr. William M. Hilbun of Tupelo.

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ORIGINAL PAPERS

Transnasal Approach to the Pituitary Gland

ROBERT R. SMITH, M.D., MYRON LOCKEY, M.D.,
DALE READ, M.D., and PATRICK LILLARD, M.D.
Jackson, Mississippi

WHEN VIEWED historically, the surgical interest in the pituitary gland has oscillated back and forth between a transcranial and transnasal approach for the past 50 years. At the end of each cycle or era, however, added knowledge of the pituitary itself or refinements in technique have resulted in overall benefits to the patient who has required pituitary surgery.

Victor Horsely probably performed the first transfrontal resection of an adenocarcinoma of the pituitary gland in 1889.¹ His challenge remained unanswered for some 17 years, however, until 1906, when Schloffer,² using a quite mutilating procedure by today's standards, performed the first transnasal pituitary operation. The entire nose was turned down on the right side, and the nasal septum, the turbinates, the inner wall of the antrum and orbit, and the floor of the sphenoid sinuses and sella turcica were resected. Later, the procedure was modified by both Von Eiselberg³ and Halstead⁴ to accomplish the same result but with less nasal destruction.

Harvey Cushing accumulated one of the largest and most successful transphenoidal surgical series. By 1914, 124 pituitary operations had been performed using this approach.⁵

Frazier,⁶ on the other hand, suggested that a transfrontal operation offered significant advantages to the transnasal if the pituitary tumor was large and the optic nerves compromised. After his refinements were published, there was a slow but definite trend away from transnasal surgery. Finally, in 1945,

Dandy expressed once again his antipathy to the views of Cushing stating, "the nasal route is impractical and can never be otherwise. At best, the actual area of exposure of the hypophysis by any nasal route is scarcely larger than the circumference of a lead pencil."⁷

Cushing, himself, finally returned to frontal craniotomy for the resection of pituitary neoplasms, admitting that visual recovery seemed better when the optic nerves could be seen and decompressed under direct vision.⁸

During the past 10 years, significant advances have been made in microsurgery which are once again causing interest in a transnasal approach to the pituitary gland.⁹ Small neoplasms within the pituitary are now often identified biochemically before radiographic evidence of pituitary enlargement occurs. Refinements in surgical techniques, particularly the use of the operating microscope, permit the surgeon to enter the sella turcica and remove these microadenomas, leaving the normal pituitary gland intact. The transnasal route is ideally suited for this purpose because of lighting, magnification and the direct visualization obtained.

Techniques of Transnasal Surgery

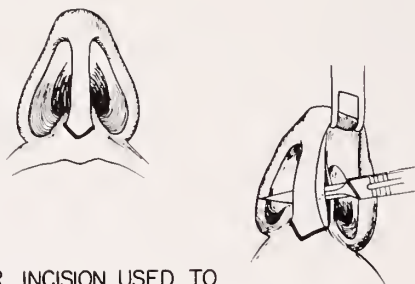
During the past seven years, the authors have employed a variety of techniques in approaching the pituitary and neoplasms in this region. The techniques which have eventually evolved preserve the nasal septum and offer significant cosmetic advantages over many other procedures. At the present time, over 20 such operations have been performed without mortality.

From the Departments of Neurosurgery, Surgery and Medicine, University of Mississippi Medical Center, Jackson, MS.

TRANSNASAL APPROACH / Smith et al

Under general endotracheal anesthesia the patient is placed in the semi-sitting position and the fluoroscope positioned so that the bony floor of the middle cranial fossa can be visualized.

A complete transfixion incision is made and extended, in V fashion, through the base of the columella in the nasolabial angle (see Figure 1). Upward retraction of the columella allows direct access to the septum and a left mucoperiosteal flap is elevated. The cartilaginous and bony portions of the septum are separated and a right mucoperiosteal flap developed over the bony septum. Detachment of the cartilaginous septum from maxillary crest and elevation of the right nasal floor mucosa allows lateral displacement of the cartilaginous septum. The bony septum is removed, permitting the floor of the sphenoid sinus to be removed (see Figure 2). The mucosa is then stripped from the sphenoid sinus and folded back exposing the floor of the sella turcica.



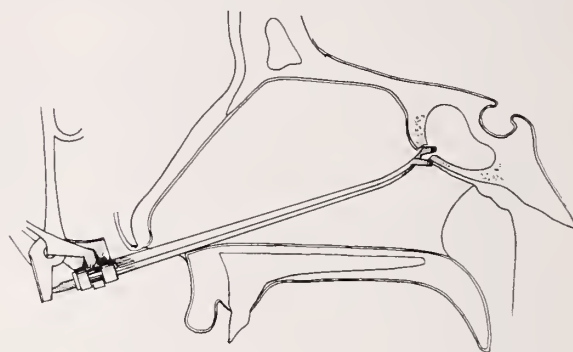
COLUMELLAR INCISION USED TO
EXPOSE CAUDAL END OF NASAL SEPTUM



Figure 1.

Using the small chisel, the sella turcica is perforated and the microscope is positioned. Suprasellar dissection is monitored using the fluoroscope. After removing 1.5 cms of the bony covering of the floor of the sella, the dura is opened exposing the pituitary gland or pituitary neoplasm, whichever the case may be (see Figure 3). Generally, the distinct borders are identified between pituitary gland and pituitary neoplasms (Figure 4). The neoplasm is of a softer consistency and different in color from the normal pituitary gland. This permits evacuation either by microdissection or suction. Magnification is adjusted so that the entire operating field comprises the contents of the sella turcica. Thorough ablative procedures can be carried out, including stalk section

and total removal of the pituitary gland if this is the surgical objective. Usually, the diaphragm of the sella can be seen and the dissection is terminated at this point. The neoplasm which extends beyond the diaphragm of the sella can often be retracted within the cavity of the sella and removed via this approach. After evacuation of the gland or neoplasm, a small muscle pack with fascia covering is placed within the pituitary fossa to seal any leak of spinal fluid or blood. Finally, a fragment of cartilage is

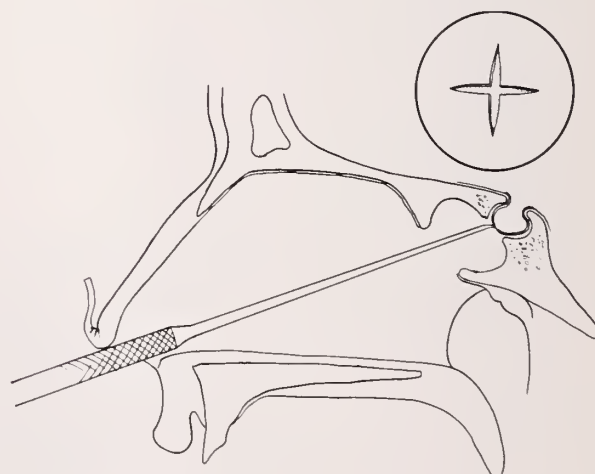


REMOVING ANTERIOR WALL OF SPHENOID SINUS

Figure 2.

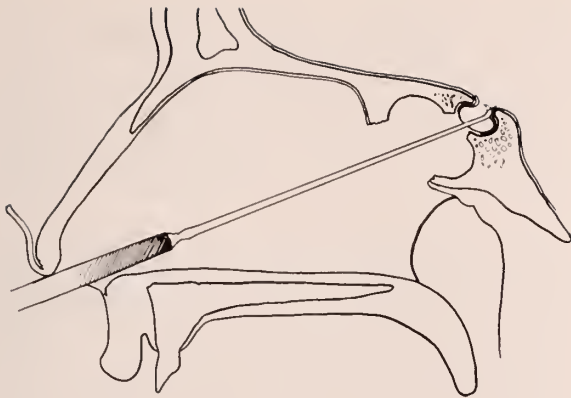
wedged into place to form a new floor to the sella turcica. The mucoperichondrial lined cavity is closed and packed into place. The mucosa and skin at the base of the columella is then closed.

Postoperatively, the patient is alert and able to



INCISING DURA OVER PITUITARY WITH
CRUCIATE INCISION

Figure 3.



PITUITARY COMPLETELY OR PARTIALLY REMOVED USING VARIETY OF INSTRUMENTS

Figure 4.

manage his own fluid requirements orally. He can usually expect to be discharged on the fifth or sixth postoperative day after nasal packs have been removed.

Comments

The general indications for hypophysectomy are listed in Table I. Unfortunately, only about one-third of all patients with metastatic breast cancer respond favorably to endocrine ablative therapy.¹⁰ Recent studies indicate, however, that in vivo and in vitro measurement of estrogen receptor activity in excised tumors may be of value in predicting the responsiveness to hormone ablation.¹¹ A small specimen (about 1.5 gms) of the original neoplasm must be frozen and preserved for a biochemical analysis. In those cases where estrogen receptor activity is

TABLE I
INDICATION FOR TRANSSPHEROIDAL
HYPOPHYSECTOMY

- | |
|-----------------------------------|
| I. Advanced cancer |
| A. Metastatic breast cancer |
| B. Metastatic prostatic cancer |
| II. Endocrine ablation |
| A. Advancing diabetic retinopathy |
| B. Acromegaly |
| C. Nelson's syndrome |
| D. Galactorrhea |
| E. Cushing's disease |
| III. Pituitary neoplasm |
| A. Chromophobe adenoma |
| B. Acidophilic adenoma |
| C. Basophilic adenoma |
| D. Pituitary apoplexy |
| E. Craniopharyngioma |

present, over half of the patients respond favorably to ablation. Hypophysectomy, adrenalectomy, and/or oophorectomy have all been employed successfully.

The role of pituitary ablation in the treatment of diabetic retinopathy has been relegated to a background position in recent years with improvement and availability of laser instrumentation for photo-coagulation.

The transnasal-transsphenoidal approach for hypophysectomy finds its prime indication in functional pituitary tumors confined to the sella turcica and is particularly suited to the treatment of acromegaly. Serum growth hormone levels greater than 10 ng/ml are usually found and these rapidly fall to normal levels following transnasal resection of the small adenoma. In Forbes-Albright syndrome (galactorrhea and amenorrhea) a functional microadenoma of the pituitary gland produces excess prolactin. Serum prolactin levels greater than 25 ng/ml in females or 15 ng/ml in males are indicative of excess prolactin production. Reduction in inhibitory factors from the hypothalamus may also increase prolactin levels, however, and produce lactation. Recent studies suggest that Bromocriptin may be able to suppress prolactin secretion and restore gonadotrophic function without the need for surgical pituitary ablation.¹² The long term effect of this agent on the pituitary microadenoma is not known, however.

TABLE II
ADVANTAGES OF TRANSSPHEROIDAL
PROCEDURES

- | |
|---|
| 1. Head shaving unnecessary |
| 2. More acceptable |
| 3. No frontal lobe retraction required |
| 4. Sacrificing olfactory nerves unnecessary |
| 5. Selective resection is possible |
| 6. Better visualization |
| 7. Complete resection possible |

Following adrenalectomy for Cushing's syndrome, a functional adenoma of the pituitary develops in up to 10 per cent of those patients carefully followed. Perhaps in some, small ACTH secreting tumors are present prior to adrenalectomy. Hypertrophied ectopic adrenal tissue sometimes results in recurrence of the syndrome even after total bilateral adrenalectomy. In most instances, the pituitary neoplasm is of the chromophobe type (Nelson's syndrome)¹³ and abrupt bleeding into the tumor may be the first sign of its presence (pituitary apoplexy).¹⁴ The transnasal-transsphenoidal approach has been used effectively in managing the above conditions with both

TRANSNASAL APPROACH / Smith et al

return of useful vision and depigmentation of the darkened skin which also commonly occurs with this disorder.

The transnasal or transsphenoidal approach to pituitary neoplasms offers several advantages. Esthetically, the procedure is more acceptable to the patient than is a craniotomy. Clipping or shaving of the hair is not required. The frontal lobes are not retracted, therefore, frontal lobe injury or hematoma is not a feature of this operation. The olfactory nerve is not disturbed and loss of sense of smell does not follow the procedure. The transfrontal approach required sacrifice of at least one olfactory nerve. Magnification and lighting are superb. The light source is directed in front of the surgeon and is therefore unobstructed. Magnification is often sufficient to allow the dissection of a small tumor and preserve the normal pituitary gland, thereby obviating the need for postoperative pituitary supportive therapy. The dangers of seizures or postoperative complications inherent with craniotomies are practically non-existent in patients submitted to transsphenoidal operations.

On the other hand, persistent CSF rhinorrhea can be expected in 1 to 2 per cent of those patients in whom the transsphenoidal procedure is carried out.¹⁵

Persistent rhinorrhea requires re-entering the sphenoid sinus and repacking the sella with muscle. Postoperative infection may lead to intracranial sepsis following transnasal surgery as it does occasionally with all other approaches. Infrequently, the carotid artery or adjacent cranial nerves may also be injured.

Transient diabetes insipidus occurs slightly more often where transnasal surgery is carried out. Apparently this results from a more thorough evacuation of the intrasellar contents. At this point, we have encountered only one persistent case.

Although cosmetic defects such as saddle nose deformity have occurred in other series, we feel that preserving the nasal septum largely prevents this complication.

Conclusion

A transnasal-transsphenoidal approach to the pituitary and to pituitary tumors has been developed at the Medical Center utilizing the operating microscope and intraoperative fluoroscopy. The nasal septum is largely preserved, and cosmetic as well as other complicating features of the operation are thus obviated. In most patients with pituitary neoplasms, this approach offers significant advantages. ★★★

2500 North State Street (39216)

Note: A complete set of references will be furnished by the authors upon request.

Among children under five, lung diseases account for 26,500 deaths a year—19,600 in the first month of life. The American Lung Association and its state affiliates are working to help protect America's greatest resource through research and medical education programs. The Mississippi Lung Association also urges the protection of children's lungs to health hazards of second-hand smoke.

Gallstones and Chenotherapy

WALTER T. BOONE, M.D.

Jackson, Mississippi

GALLSTONES RECOVERED from Egyptian mummies attest to the ancient history of this affliction. Gallstones are a major health problem in the United States today affecting 12 million women and 4 million men. Approximately 330,000 cholecystectomies are performed annually accounting for almost a billion dollars a year in hospitalization and other medical expenses. Research in cholelithiasis entered an accelerated phase about 10 years ago stimulated by increased awareness of gallstones as a major health problem. Almost 90 per cent of gallstones analyzed in the United States are composed predominantly of cholesterol; the remaining 10 per cent are composed principally of bilirubin. The following discussion of cholelithiasis will be limited primarily to those predominantly cholesterol stones.

The classical five F's of cholelithiasis include fair, fat, female, forty and fertile. Indeed, only the female part of the classic five F's is clearly associated with an increased incidence of gallstones.¹

Gallstones have traditionally been associated with people of a fair complexion. In fact, the major incidence of gallstones occurs in the populations of Europe as well as the United States. The Pima Indians represent a special subsection of our population in that 70 per cent of the Pima Indian women have gallstones by age 30 and 70 per cent of the men have gallstones by age 60. In contrast, studies in Japan show a prevalence of less than 5 per cent of cholelithiasis and in the Masai tribe of East Africa gallstones are practically unknown.

Several studies have suggested a relationship between gallbladder disease and obesity. An autopsy study showed that subjects with cholelithiasis weighed more than normal subjects and a clinical study indicated that women with symptomatic gallstone disease had greater skin fold thickness than carefully matched controls.² The Framingham population study further demonstrated that patients with clinical gallbladder disease weighed more than those without disease.³ Perhaps the most radio-opaque study included that of Bennion and his colleagues⁴ when they demonstrated that lithogenic bile was prominent in obese patients and could be improved

significantly with a mean total weight loss approaching 50 pounds. In most cases this decrease in lithogenicity of bile was due to a decrease in cholesterol secretion.

Gallstones represent a major health problem in the United States affecting 16 million people. The majority of gallstones are composed of cholesterol. Of the classical five F's, only femaleness is statistically significant.

This report examines the constituents of bile and the mechanism of formation of lithogenic bile. The current status of medical dissolution of cholelithiasis with chenodeoxycholic acid is reviewed.

The incidence of cholelithiasis is higher in multiparous patients than in nulliparous patients. Exogenous estrogens and progestins have been found to increase the cholesterol concentration in bile of laboratory animals and a similar mechanism has been postulated to occur in human bile. An association between surgically confirmed gallbladder disease and estrogen therapy in postmenopausal women has also been reported.⁵ Interestingly, gallbladder bile seems to be significantly more saturated with cholesterol during contraceptive therapy than during normal menstrual cycling.⁶ These findings suggest that exogenous sex steroids in doses and formulations routinely prescribed induce important alterations in the composition of human gallbladder bile. This fact may provide a biochemical basis for the increase in gallbladder disease observed among women using oral contraceptives.

Ten per cent of men and 20 per cent of women between the ages of 55 and 65 years have gallstones making an overall total exceeding 15 million people. The incidence is greater in females over 40 than females under 40. The incidence is greater in females over 40 than in males of any age. There is relatively little physiological data to explain these findings unless one suggests that a stagnant gallbladder is a concomitant of life after 40.

Flatulence, gaseousness, burping, dyspepsia, and fatty food intolerance are no more prominent in pa-

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tients with radiographically nonfunctioning gallbladders than in patients with normal gallbladder studies.⁷

There are several diseases which do have an increased incidence of cholesterol cholelithiasis. Regional enteritis and surgical resection of the terminal ileum result in a striking increase in cholelithiasis, explicable by the functional or anatomical loss of the site of absorption of bile salt located in the terminal segment of the ileum. Diabetes mellitus is associated with an increased incidence of gallstones.

Cholesterol precipitation is the prerequisite for the development and growth of cholesterol gallstones. Bile that is saturated or supersaturated with cholesterol or that contains cholesterol crystals is termed lithogenic bile. The solubility of cholesterol in bile is determined primarily by the relative proportions of bile acids phospholipids and cholesterol in the bile. Lithogenic bile may be defined as bile which is supersaturated with cholesterol and can be plotted as a ratio between cholesterol, bile salt and lecithin in bile (see Figure 1). Indeed, most patients with cholesterol gallstones have bile containing excess cholesterol while subjects without stones have bile compositions lying outside the shaded area of Figure 1.

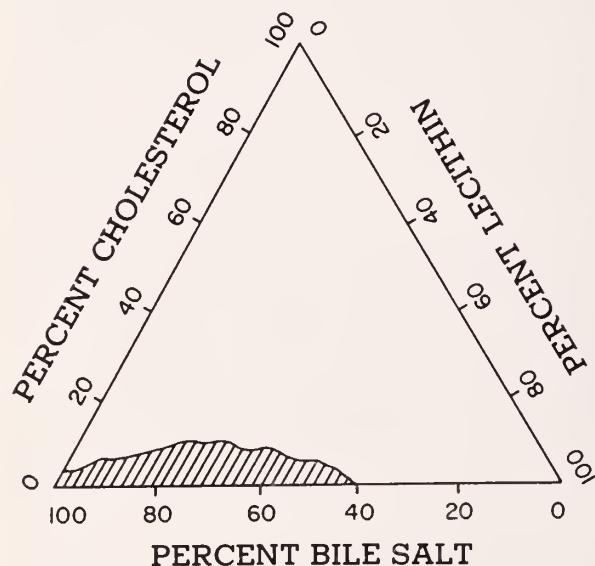


Figure 1. Composition of gallbladder bile. Lithogenic bile represented by shaded area.

The primary bile acids, cholic acid and chenodeoxycholic acid are formed in the liver as the major catabolic products of cholesterol (see Figure 2). The amount of bile salts produced from cholesterol is determined by the enzyme 7 alpha hydroxylase and is delicately controlled by the enterohepatic circulation of bile salts returning to the hepatocyte. Other

enzymes are important steps in production of the two primary bile acids, chenodeoxycholic acid and cholic acid. The primary bile acids are conjugated with glycine and taurine prior to being secreted into the intestinal tract. Once in the gastrointestinal tract, they are degraded by bacterial enzymes to the secondary bile acids which consist of deoxycholic acid and lithocholic acid. By an active process limited to the terminal ileum, bile salts are reabsorbed into the enterohepatic circulation.

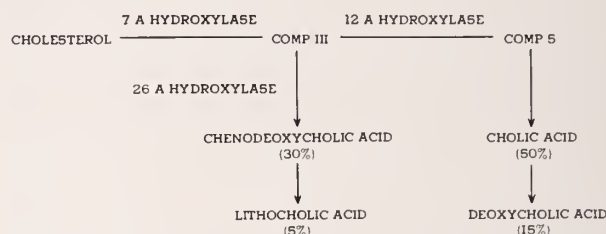


Figure 2. Enzymatic regulation of bile acid synthesis from cholesterol.

The bile salt pool is approximately 4.5 gms in the adult and is composed of 50 per cent cholic acid, 30 per cent chenodeoxycholic acid, 15 per cent deoxycholic acid, and 5 per cent lithocholic acid. This bile salt pool recirculates twice with each meal or about six times daily. During the daily enterohepatic circulation of bile salts, approximately 500 of bile salt are excreted into the feces.

Cholesterol enters the bile as a product of acetate metabolism (see Figure 3). Many steps have been deleted between acetate and mevalonic acid but the rate limiting enzyme of cholesterol production by the liver is HMG-CoA reductase. The feedback control of cholesterol synthesis by the liver is mediated by this enzyme. Factors such as absorbed cholesterol and the enterohepatic circulation of bile salt are believed to influence cholesterol synthesis by affecting

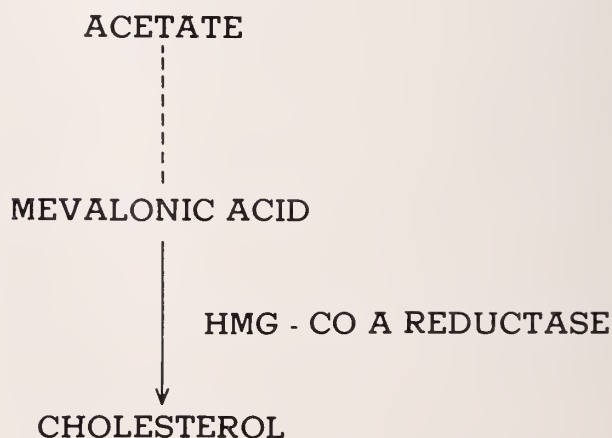


Figure 3. Metabolic pathway of hepatic cholesterol synthesis.

either the formulation or degradation of hepatic microsomal HMG-CoA reductase.

Relatively little attention has been paid to lecithin in the bile salt literature over the last five to 10 years. Lecithin secretion into bile is thought to be mediated by a feedback control mechanism of microsomal bile salt concentration from the enterohepatic circulation.

There are several theoretical mechanisms for the formation of lithogenic bile. The most common mechanism of lithogenic bile formation is related to an increased concentration of cholesterol and a decreased concentration of bile salts. However, lithogenic bile does not a gallstone make and there are additional biochemical and pathological features that lead to the final product of a gallstone. Initially, there must be a saturation stage in which cholesterol is found in a supersaturated form (lithogenic bile). The rate of stone growth must be determined by the balance between the rate of precipitation of cholesterol crystals and the rate of their dissolution or passage into the intestinal tract. Nucleation of abnormal bile may be due to bacteria, mucus, precipitated bile salts or other foreign bodies. Gallstones ordinarily grow in the gallbladder where bile remains for several hours before being emptied into the duodenum. The frequency and efficiency of gallbladder emptying may thus play an important role in the growth stage of cholesterol gallstones.

In preListerian times, when conservative measures were the only means available to the doctor for the relief of his patients, it was hardly surprising that numerous brews, potions and diets were recommended as a cure for gallstones. In the early days of surgery when operative mortality was high, it was natural that special efforts should have been made to discover a means of safely dissolving gallstones, thereby avoiding a hazardous operation. As surgical techniques improved, the incentive to find a medical cure for cholelithiasis became less. The medical profession became increasingly disenchanted as repeated attempts to dissolve gallstones proved either ineffective or potentially dangerous. Consequently, surgery has been our mainstay of treatment for symptomatic cholelithiasis.

Dissolution of gallstones has been toyed with since 1891 when various noxious substances such as ether and chloroform and turpentine were used to dislodge retained common duct stones. The potential dangers of these agents precluded their use. Patients with cholesterol gallstones have two important differences in comparison to normal patients. Gallstone patients have a total bile salt pool which is lower than normal and the percentage of chenodeoxycholic acid is also lower. An agent that could expand the

bile salt pool, increase concentration of chenodeoxycholic acid and decrease the concentration of cholesterol in bile would be useful in the medical dissolution of gallstones. As a result of its cholesterol holding capacity, the bile should be able to solubilize additional cholesterol and as a consequence bring about the dissolution of cholesterol gallstones exposed to it. Crude bile salts and bile acid feedings were first used in 1939 and in uncontrolled observations in 1957 stones were seen to disappear from cholangiograms after administration of bile extracts for periods of 8 to 13 weeks. As encouraging as these early reports were, the real breakthrough did not come until a more systematic study was made of the effects of feeding individual bile salts in comparatively pure forms.

In 1971 Thistle and Schoenfield⁸ demonstrated that the cholesterol solubilizing capacity of the bile of gallstone patients was dramatically increased by giving one gram of chenodeoxycholic acid per day. This important observation was confirmed both in Caucasians and in North American Indian women. At last an agent had been found which would consistently enhance the cholesterol solubility of human bile. Chenodeoxycholic acid seems to be effective because it expands the bile salt pool increasing the bile salt concentration in liver bile and more importantly, it decreases hepatic cholesterol synthesis by its action on the rate limiting enzyme HMG-CoA reductase.

Chenodeoxycholic acid therapy is effective and the cumulative experience with this drug indicates that at least two-thirds of the patients who are treated for a one year period of time have significant reduction in the size of their gallstones or dissolution.

On the whole chenodeoxycholic acid is well tolerated by patients and there is a subjective impression that the symptoms of many patients improve during treatment. The majority of patients treated note an increased frequency of bowel motions or even frank diarrhea when treatment is instituted. In the vast majority of cases this settles down spontaneously or after a slight reduction in dosage. The diarrhea is almost certainly due to unabsorbed, free chenodeoxycholic acid inducing the colon to secrete water and electrolytes. Feeding an exogenous bile acid such as chenodeoxycholic acid might theoretically block indigenous bile acid synthesis from cholesterol and consequently increase the cholesterol pool. This would in turn have an undesirable effect of promoting atherosclerosis. Careful studies thus far have not revealed any evidence of an increase in either the serum cholesterol level or the exchangeable cholesterol pool.

Perhaps the most serious consequence of chenodeoxycholic acid is the resultant hepatotoxicity. In many experimental animals, particularly in non-human primates, hepatotoxicity has been a major side effect of chenodeoxycholic acid therapy. It may be due to the chenodeoxycholic acid itself or its metabolite, lithocholic acid. However, in contrast to the studies with experimental animals, the available evidence in man suggests that in doses up to 1½ gm per day chenodeoxycholic acid is not significantly hepatotoxic. Man is probably protected from hepatotoxicity by two biochemical features. Man sulfates lithocholic acid making it poorly absorbed by the terminal ileum. In man chenodeoxycholic acid is epimerized possibly decreasing its toxicity. In Thistle and Hoffman's experience,⁹ 9 of the 31 patients showed transient rises in SGOT levels which returned spontaneously to normal with continued chenodeoxycholic treatment. In those same patients, no change in serum protein, bilirubin, alkaline phosphatase, or gamma glutamyl transpeptidase levels were noted during chenotherapy. Well controlled studies of liver biopsies in patients with gallstones treated and not treated with chenodeoxycholic acid showed only minor histological differences.

Dissolution treatment of gallstones with chenodeoxycholic acid is still experimental. Efficacy is virtually certain, but safety remains to be shown in a large scale therapeutic trial. Numerous questions still remain regarding the least effective dose as well as duration of treatment. Within three months after chenotherapy is discontinued, bile becomes saturated with cholesterol and recurrence of gallstones has been reported in 10 per cent of the patients within one year. It is obvious that continued prophylactic doses of chenodeoxycholic acid will be necessary, at least for some patients.

Future studies are indicated to define the minimum required dose of chenodeoxycholic acid, to gather more information on its safety during prolonged

administration, and to define its value in the treatment of biliary-duct stones. If further studies continue to document efficacy and safety, assessment of prophylactic chenotherapy, especially in high risk groups, should be initiated.

In the United States chenodeoxycholic acid therapy is in clinical trials supported by the National Institutes of Health as the National Cooperative Gallstone Study. This study involves patients with cholesterol cholelithiasis at 10 university centers. These patients are being treated with a high dose, a low dose and a placebo with liver biopsies performed at six month intervals. This study hopefully will answer those questions raised as to the safety and indications for chenodeoxycholic acid therapy as an alternate form of management of symptomatic cholelithiasis. The development of chenodeoxycholic acid as an effective therapeutic agent for gallstones underscores the tremendous importance of applied research in basic pathophysiology. ★★★

Suite 415, 971 Lakeland Drive (39216)

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Two elderly couples vacationing together decided to fight high travel prices by sharing a motel room every night with two double beds.

After the four came home, a neighbor asked, "But wasn't modesty a problem?"

"Not at all," said one of the travelers. "At bedtime we just took off our bifocals."

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

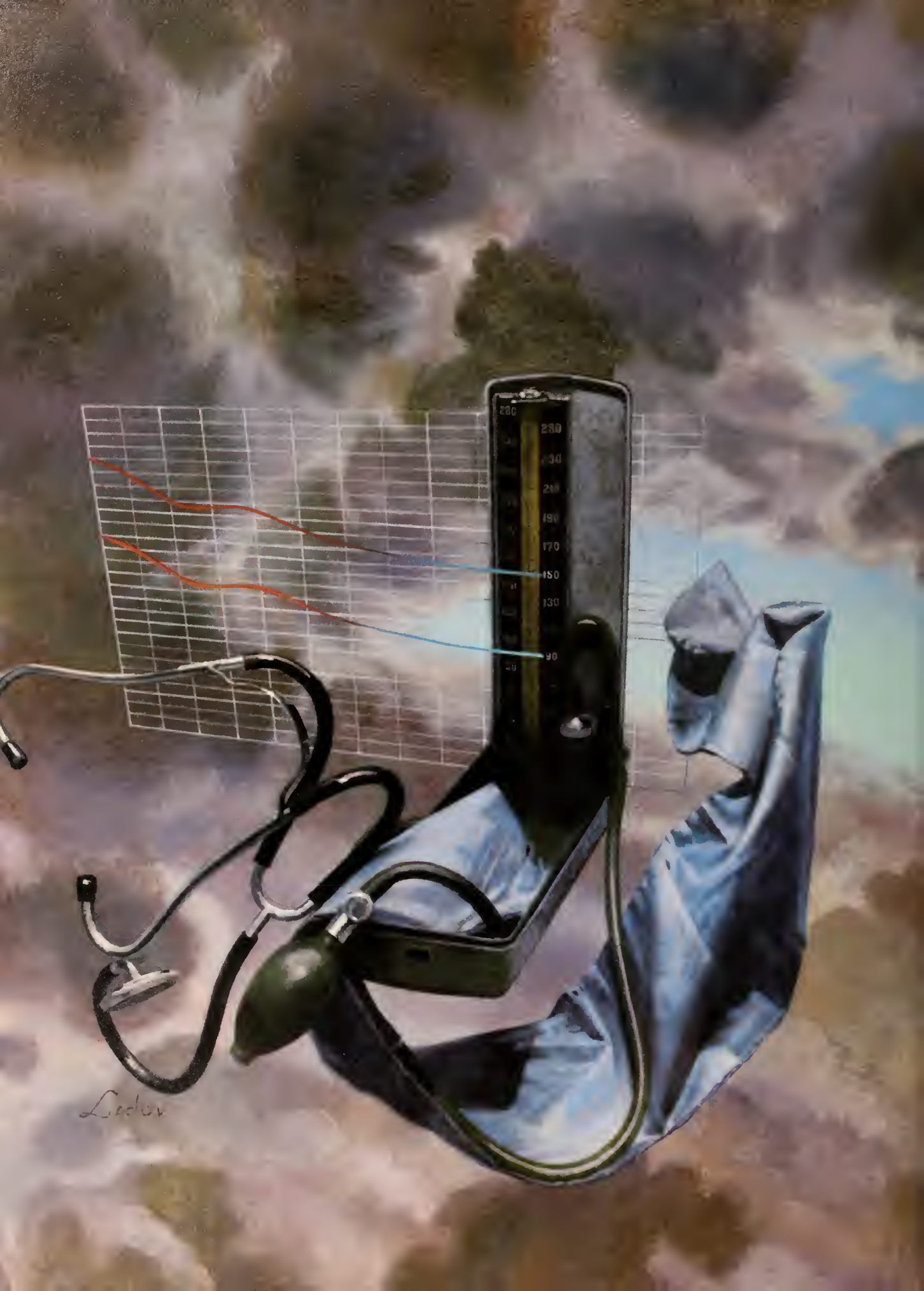
affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Lecler

When choosing a diuretic for day-in-day-out hypertension control with comfortable compliance...

The agent you choose in mild to moderate essential hypertension should offer (1) long-term effectiveness, (2) patient comfort, and (3) compliance.

Zaroxolyn offers all three.

Effectiveness: In several long-term studies^{1,2,3} Zaroxolyn brought moderately elevated blood pressure (average 167/113 mm Hg) down to the range of normotension—and held it there for up to four years.

Comfort-in-use: One investigator noted, "Patient cooperation was surprisingly good for a study of such duration. The once-daily schedule with metolazone (Zaroxolyn) no doubt contributed to patient compliance."

Overall compliance with Zaroxolyn is good—very good. An analysis of controlled clinical studies involving 188 Zaroxolyn patients showed that only eight discontinued therapy because of side effects. That's a discontinuation rate of only 4.3%, and broader clinical experience appears to substantiate this low rate.³

Long-acting **Zaroxolyn**[®] (metolazone) Pennwalt 3½ mg, 5 mg and 10 mg tablets once-daily antihypertensive diuretic

Recommended initial dosage in mild to moderate essential hypertension—2½ to 5 mg once daily


Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed

against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyper-

glycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg, edema of cardiac failure—5 to 10 mg, edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

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TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, "we shall betray all of those who have died in order that we might meet here in freedom and safety to create it."

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the

Social Security Bill Is Signed; Gives Pensions to Aged, Jobless

Roosevelt Approves Message Intended to Benefit 30,000,000
Persons When States Adopt Cooperating Laws—He Calls
the Measure 'Cornerstone' of His Economic Program.

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10,
1971—The Senate approved
today 94 to 0 and sent to

WASHINGTON, Aug. 14, 1935
The Social Security Bill, providing a broad program of unemployment insurance and old age pension and counted upon to benefit some 20,000,000 persons, became law today when it was signed by President Roosevelt in the presence of those chiefly responsible for putting it through Congress.

Mr. Roosevelt called the measure "the cornerstone in a structure which is being built by the means of the Social Security Act."

COMPL

the Draft Ends Now

WASHINGTON, Jan. 27,
1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
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Radiologic Seminar CLXXIV: Sarcoidosis

JUNE G. BLOUNT, M.D.

Jackson, Mississippi

SARCOIDOSIS is a granulomatous, systematic disorder which occurs mainly in young adults, with a predilection for blacks. Although the etiology is unknown, an anergic form of tuberculosis has been considered a possibility. The disease usually has its inception in the chest, but virtually every organ and system may be affected.

Lesions of the skin and eyes may be present, and hepatomegaly and lymphadenopathy may occur. Skeletal involvement may cause arthralgia and crippling deformities of the hands, usually associated with dermatological abnormalities.

Diagnosis may be confirmed by a positive liver or scalene node biopsy. An intradermal Kveim test is usually diagnostic, but evaluation of the skin reaction is often long delayed. Recent studies suggest the Kveim test is not specific for sarcoidosis, but may be related to elevation of the blood serum globulins.

Pathologically, sarcoidosis is a non-caseating granulomatous disorder. Occasionally, necrosis and secondary calcification may be present.

Radiological Features

Radiologic features are described as follows:

CHEST: Hilar and mid-mediastinal lymphadenopathy and disseminated interstitial and sometimes alveolar pulmonary infiltrates in varying combinations.

SKELETON: Involved in approximately 14-36 per cent of all cases of sarcoidosis. The hands and feet are most commonly affected.

HANDS AND FEET: Eight types of lesions:

1. Well-defined, generally small lytic defects in the metaphyseal ends of the phalanges and occasionally the metacarpals and metatarsals. These defects correspond to the sites of the nutrient foramina, in juxta articular areas.
2. A reticulated lace-like, destructive mottled pattern, mainly confined to the metaphyses, but may affect the entire bone.

3. Well-defined, larger radiolucent defects in the phalanges, metacarpals and metatarsals, simulating enchondromata, particularly when calcification occurs.
4. Neuropathic-like lesions, mainly of phalanges, simulating scleroderma and leprosy.
5. Punctate or diffuse areas of endosteal bone sclerosis.
6. Subperiosteal erosions, simulating hyperparathyroidism. Rare.
7. Periosteal reaction. Rare.
8. Soft tissue nodules. Rare.
9. Relative lack of osteoporosis.

Unusual manifestations of sarcoidosis in the remainder of the skeleton include:

1. Lesions in long bones, usually well-defined radiolucent defects with sclerotic borders.
2. Lytic lesions of vertebral bodies simulating tuberculosis, but with well-preserved disc spaces.
3. Paraspinal masses and extradural block on myelography.
4. Well-defined lucent calvarial defects.



Figure 1. HANDS: Gross deformity and swelling of soft tissues of digits. Extensive destructive expansile cystic and reticulated lesions of phalanges, right 4th and 5th metacarpals, left 1st metacarpal. Subperiosteal cystic lesion in the distal right radius. Left radial epiphysis and shaft involved.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi Medical Center, Jackson, MS.



Figure 2. *RIGHT FOOT*: Both feet were relatively symmetrically involved. Punched-out, lytic, cystic metaphyseal defects and coarsened reticulated destructive trabecular pattern in 1st and 5th digits. Fracture of proximal 5th metatarsal. Cystic lesions in 1st cuneiform, calcaneus, distal tibia and fibula.



Figure 3. *TIBIA AND FIBULA*: Circumscribed cystic lesions are in the distal tibia and fibula. There is a reticulated destructive trabecular pattern in the distal fibula involving both cortex and medullary cavity. The proximal tibial epiphysis is involved.

5. Grossly destructive lesions of the nasal and jaw bones.
6. Of interest is the recent recognition of localized and widespread diffuse bone sclerosis of the hematopoietic skeleton, reminiscent of myeloid metaplasia or osteoblastic metastases. Bone biopsies substantiate the diagnosis of sarcoidosis.

Case Report

Systemic sarcoidosis is demonstrated in this 14-year-old black male with pulmonary, ocular, skin and bone involvement. (See Figures 1, 2 and 3.)

Diagnostic biopsies were obtained from a right paratracheal node, a granuloma of the fourth finger of left hand, and conjunctiva of left eye. ★★★

2500 North State Street (39216)

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The President Speaking

Health Care Costs

JAMES O. GILMORE, M.D.
Oxford, Mississippi

WE ALL have three basic options in facing the problem of rising medical and hospital costs which, according to a generally sympathetic study by the Robert Wood Johnson Foundation, may "prove to be the Achilles' heel" of the present system of care.

One option is simply to justify the costs by validly citing such reasons as longevity-related chronic illness, new technology and techniques, broader insurance as a stimulus to broader services, and general inflation. But doing so is effective *only up to a point*.

A second option is to let the federal government make political hay out of rising medical prices.

The third alternative, and ultimately the pragmatic one, is to develop and pursue our own initiatives against climbing costs.

We have to be aware that the government while it often exploits public issues does not pull them out of the blue. It is responding to widespread public concern about health-care costs.

It's significant that we physicians, too, are tending to see the cost problem as overwhelming. And it's stimulating to read what the Medical Association of Georgia (MAG) has urged.

A report acted upon by the MAG House of Delegates—at its last annual session—declared, "Physicians must look at the cost of health care." The delegates adopted such recommendations as these:

- "Establishment of community meetings on health care costs to be composed of representatives from labor, management, local county medical societies, hospitals, the media and consumer interest groups, to be selected by the county medical societies." (The first such Georgia meeting is targeted for January.)

- Urging insurance companies to eliminate first-dollar coverage, use deductible and co-insurance, and expand outpatient benefits.

- Upgrading of medical audit procedures in hospitals. Restrictions on costly additional services, such as private room and private nurse services, by insurance carriers. Encouraging hospital medical staffs to inform themselves about costs.

- Encouraging local physicians to be active on task forces, committees, and boards of directors of the Health Systems Agencies called for by the Health Planning Act of 1974, "to assure that the best interests of patients are considered in all HSA decisions."

- Requesting assistance from medical schools in presenting the cost problem to their students.

Forces in Washington, D. C., have a big chip on their shoulder concerning the price of medical and hospital services. Let's think beyond the chip—and about the future of our professional freedom. Let's put our own shoulders to the cost-control wheel. ★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XVIII, NUMBER 10
OCTOBER 1977

Emergency Medical Services

Emergency Medical Services are alive and growing in the state of Mississippi! For the past three years, the Emergency Medical Services Program has made marked increases both in the northern and southern parts of the state of Mississippi. This growth has been brought about by public awareness as well as concerned individuals in the fields of local government and medicine.

These programs have survived because committed physicians have encouraged elected public officials to become involved. This same commitment is needed throughout the state so that a total statewide Emergency Medical Services network can be developed. Support of the medical community is mandatory for this development to be successful.

Through the work of physicians in the state, several projects have gained national impetus, and have been included in seminars throughout the country. We as physicians in Mississippi have the opportunity not only to improve the delivery of emergency medical care, but to make Mississippi a showplace for the southeastern part of the United States. The College of Surgeons Trauma Committee along with the Emergency Medical Services Advisory Board, the State Board of Health, and the University of Mississippi Medical School are in the process of trying to implement continued medical education courses for physicians in emergency medicine as well as develop guidelines in all critical care areas. Hopefully, some information on these courses and the forthcoming guidelines will be published within the next several months.

It is anticipated that all physicians in Mississippi will take an interest in either teaching or attending these Emergency Medical Services Seminars when they are offered.

With physician commitment we not only improve the care of our patients but make ourselves better physicians.

W. BRIGGS HOPSON, JR., M.D.
State Medical Control Director
Emergency Medical Services
Vicksburg, MS

Medico-Legal Brief

Court Enjoins Chiropractor From Practicing Medicine Without License

The Mississippi State Medical Association was entitled to an injunction barring a chiropractor from using electrotherapy devices and dispensing or prescribing vitamin and mineral supplements, a Mississippi trial court ruled.

The medical association claimed that the chiropractor was practicing medicine without a license. He used microwave diathermy machines, ultrasonic devices and electric muscle stimulators in his practice. He also recommended, prescribed and dispensed OTC vitamin and mineral supplements.

After concluding that the medical association had standing to bring the suit, the trial court reviewed the statutes governing the practice of chiropractic and the practice of medicine. The court said that some degree of overlapping in the use of certain equipment by the two professions was necessary. However, several physicians testified to the hazards and risks associated with the use of electrotherapy devices. The court permanently enjoined the chiropractor from using microwave diathermy and ultrasonic devices and electric muscle stimulators on his patients.

Other procedures used by the chiropractor prep-

MEDICO-LEGAL / Continued

aratory and complementary to the adjustment of articulations were within the scope of his practice. The court did not enjoin him from continuing to use traction equipment, braces, moist heat, spinal pelvic stabilizers and electric vibrators.

As to his recommendation, prescribing and dispensing of vitamins, the court said that they were classified as drugs under Mississippi laws. Only licensed physicians could prescribe or dispense drugs, the court said. It was not the distribution and sale of vitamins and food supplements that was prohibited, since they were available for sale at pharmacies and supermarkets without a prescription, but the recommendation or prescribing of them. The court enjoined the chiropractor from prescribing, recommending or suggesting vitamins and minerals.—*Mississippi State Medical Association v. Norville* (Miss. Chancery Ct., Hinds Co., Docket No. 98,915, March 8, 1977)

PERSONALS

BRYAN BARKSDALE of Jackson has associated with The Medical Clinic, P.A. of Jackson for the practice of internal medicine at 746 Manship Street.

KENNETH R. BENNETT of Jackson announces that he is now in private practice for consultative cardiology at 2169 University Drive in Jackson.

MICHAEL BROOKS of Laurel was recently welcomed as a new professional member of the Laurel Chamber of Commerce.

MICHAEL H. CARTER, JR., announces the opening of his office for the treatment of diseases of the ear, nose and throat, facial plastic and reconstructive surgery at 204 8th Street in Greenwood.

DOUGLAS E. CLARK has associated with Radiology of Tupelo P.A. for the practice of radiology at 835 South Gloster Street in Tupelo.

R. HUGH FLEMING has set up his offices for the practice of neurology in the Coastal Medical Center in Biloxi.

WENDELL N. GILBERT, SR., announces the opening of his office for the family practice of medicine at 2207 15th Street in Meridian.

THOMAS L. GRAVES and RICHARD H. TILLEY announce the opening of their office for the practice of internal medicine at 4300 West Beach in Gulfport. CHARLES GUICE of Hattiesburg addressed the Hattiesburg unit of the American Diabetes Association-Mississippi affiliate, at the Hattiesburg Clinic meeting room. Dr. Guice discussed special problems of the diabetic when surgery is performed and how pain and stress can affect diet and insulin requirements.

PRENTISS F. KEYES has resumed his practice in DeKalb after a stint in the U.S. Air Force. Dr. Keyes is in family practice.

ACHIN KIM has associated with RUSSELL R. LYLE of Starkville for the practice of allergy in children and adults at Medical Arts Clinic, 517 University Drive.

FRED J. McDONNELL has associated with T. F. McDONNELL, LAMAR PURYEAR, and JOHN H. LONG of Hazlehurst for the practice of family medicine at the Hazlehurst Clinic.

JAMES B. PENNEBAKER of Jackson and UMC spoke on vasculitis—as a mechanism of tissue injury in rheumatic states at the Third Annual Symposium on Arthritis and Musculoskeletal Diseases in Point Clear, AL.

THOMAS POOTHULLIL has opened his offices for the practice of internal medicine and diseases of the lung and respiratory tract in the Coastal Medical Center Building in Biloxi. He has also been appointed medical director of the Respiratory Therapy Department at Gulf Coast Community Hospital.

PHILLIP ROGERS of Hattiesburg discussed kidney disease in diabetics at the meeting of the Hattiesburg unit of the American Diabetic Association.

L. CONRAD ROWE has opened his office for the practice of orthopedic surgery at the office complex of Garden Park Hospital in Gulfport.

WILLIAM SHOUSE has associated with JAMES R. FOSTER in the Coastal Medical Center in Biloxi for the practice of internal medicine.

DEATHS

CALLENDER, CLAUDE G., Jackson. Born Meadville, MS, Mar. 31, 1917; M.D., Tulane University School

of Medicine, New Orleans, LA, 1942; interned Charity Hospital, New Orleans, one year; obstetrics and gynecology residency, same, 1943-45; died Aug. 17, 1977, age 60.

EVANS, BEN PICKERING, Grenada. Born Fulton, KY, Oct. 29, 1917; M.D., Tulane University School of Medicine, New Orleans, LA, 1953; interned Charity Hospital, New Orleans, one year; surgery residency, Ochsner Foundation, 1950-55; died Aug. 5, 1977; age 59.

NEW MEMBERS

BOMBOY, DAVID W., Hattiesburg. Born Hattiesburg, MS, Mar. 7, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned UMC, Jackson, MS, one year; orthopedic surgery residency, same, 1972-76; elected by South Mississippi Medical Society.

CRONIN, IRVIN H., Jackson. Born Purvis, MS, July 29, 1929; M.D., University of Mississippi Medical School of Medicine, Jackson, 1960; interned USPHS, Norfolk, VA, one year; elected by Central Medical Society.

HERRING, JACK L., Magee. Born Duck Hill, MS, May 31, 1930; M.D., University of Tennessee College of Medicine, Memphis, TN, 1955; interned Baptist Hospital, Jackson, MS, one year; elected by Central Medical Society.

MURRAY, ROGER C., Houston. Born St. Paul, MN, May 7, 1925; M.D., University of Minnesota Medical School, Minneapolis, 1952; interned Hitchcock Memorial Hospital, Hanover, NH, one year; elected by Northeast Mississippi Medical Society.

TAYLOR, JESSIE R., Verona. Born Verona, MS, Sept. 13, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned Baptist Memorial Hospital, Memphis, TN, one year; elected by Northeast Mississippi Medical Society.

WAGNER, DONALD F., Biloxi. Born Milwaukee, WI, Oct. 5, 1944; M.D., University of Wisconsin Medical School, Madison, 1970; interned San Joaquin County Hospital, Stockton, CA, one year; orthopedic surgery residency, same, 1971-72; orthopedic surgery residency, University of Texas, Galveston, 1972-76; elected by Singing River Medical Society.

POSTGRADUATE CALENDAR

Oct. 17-21, 1977

FAMILY PRACTICE REVIEW

Holiday Inn Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Family Medicine and University Medical Center Division of Continuing Health Professional Education.

Coordinators: Ian Cameron, M.D., assistant professor of family medicine, University of Mississippi School of Medicine and Roland B. Robertson, M.D., assistant vice chancellor for Veterans Administration affairs and acting director of Continuing Health Professional Education, University of Mississippi Medical Center, and assistant professor of medicine, University of Mississippi School of Medicine.

This week-long course is designed for the primary care physician who wants to review new developments in family practice in preparation for the family medicine board examination. Fee: \$150. Credit: 40 contact hours. 4.0 CEU, Category 1, AMA; AAFP.

Nov. 10-11, 1977

CARDIOVASCULAR REVIEW—1977

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Departments of Surgery, Medicine and Pediatrics, and the University of Mississippi Medical Center Division of Continuing Health Professional Education.

Coordinator: James D. Hardy, M.D., professor of surgery and chairman of the department, University of Mississippi School of Medicine.

This two-day course is for internists, cardiovascular surgeons and general practitioners who deal with cardiovascular problems. UMC faculty will join guest faculty in discussions on chronic heart failure, heart murmurs, diet and heart disease, phlebitis with and without pulmonary embolism, infections on cardiovascular patients, and noninvasive diagnosis of arterial and venous disease. Registration is limited to 150, and advance registration is required. Fee: \$100.00. Credit: 17 contact hours, 1.7 CEU. Category 1, AMA; AAFP.

POSTGRADUATE / Continued

Nov. 18, 1977

HEMOPHILIA SOCIETY MEETING

Downtowner Motor Inn, Jackson

Sponsored by the Hemophilia Society and the University of Mississippi Medical Center Division of Continuing Health Professional Education.

Coordinator: Glenda Scallorn, M.D., St. Dominic Mental Health Center.

Annual business meeting and scientific session open to physicians, dentists, and nurses. Guest faculty are Ake Mattsson, M.D., professor of psychiatry and pediatrics, University of Virginia Medical Center, Charlottesville; Marvin S. Gilbert, M.D., assistant clinical professor of orthopedics, Mount Sinai School of Medicine, New York City; and Louis M. Aledort, M.D., vice chairman of the Department of Medicine, Mount Sinai School of Medicine, New York City. UMC faculty are Francis Morrison, M.D., professor of medicine and director, division of hematology; John F. Jackson, M.D., professor of preventive medicine and associate professor of medicine; Jeannette Pullen, M.D., associate professor of pediatrics; Frazier Ward, M.D., assistant professor of surgery (orthopedics) (part-time); and Mark Helpin, D.M.D., assistant professor of pediatrics dentistry and director, maternal-child health dental program. Fee: \$20.

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

FUTURE CALENDAR

Dec. 3, 1977

COMMON HAND INJURIES

Mississippi Methodist Rehabilitation Center

Dec. 14, 1977

HYPERTENSION SEMINAR

Jan. 9-13, 1978

EKG INTENSIVE COURSE

Mar. 9-11, 1978

SURGICAL FORUM V

Holiday Inn Downtown, Jackson

Mar. 30-April 1, 1978

GASTROENTEROLOGY UPDATE

Ramada Inn Coliseum, Jackson

LETTERS

SIRS: Bacterial meningitis is a medical emergency. Delay in treatment invites neurologic disability or death. This diagnosis should receive at least momentary consideration in any patient with *nuchal rigidity*, *clouded sensorium* or *impaired consciousness*, *headache*, *fever*, or a *petechial* or *purpuric* rash. Begin antibiotic therapy as soon as a presumptive diagnosis of bacterial meningitis is made without awaiting bacteriologic confirmation.¹

H. influenzae meningitis is impossible to distinguish from other purulent meningitides on the basis of signs and symptoms alone.

Current Therapy 1977 suggests the following antibiotic therapy for acute cases in patients with normal renal functions:

For adults: Ampicillin: 12 gms/day IV divided into 6 doses.

For pediatric cases: 400 mg/kg/day IV divided into 6 doses.

Chloramphenicol is the recommended alternative drug if a history of penicillin allergy is known. Recommended dosage is:

Adults: Chloramphenicol: 50-100 mg/kg/day IV, divided into 4 doses (50 mg/kg/day usually suffices except in meningitis due to coliforms).

Pediatric cases: 100 mg/kg/day IV divided into 4 doses.

Note: Current manufacturer's official directive for each antibiotic listed should be read before using.

Because of the recent occurrence of Ampicillin resistant Group B isolates, chloramphenicol has been recommended by some for initial therapy in documented or suspected severe *H. influenzae* Group B infections.²

The case fatality rate is about 5 per cent. One should aim not only at survival but at prevention of sequelae, including the more subtle forms of CNS damage.³

Recent studies conducted by the Center for Disease Control indicated that secondary cases within the household of the case of *H. influenzae* meningitis will occur at approximately the same rate as with household contacts to meningococcal meningitis.

Until more definitive recommendations are outlined, household contacts who are the same age or younger than the patient should be prophylactically treated with ampicillin or rifampin or these contacts should be very closely observed for at least 1 month



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx 1,000 tons)

- **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.
- **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.
- **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG 
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert[®]/25 
(meclizine HCl) 25 mg. Tablets
for vertigo*

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE **DYAZIDE®**

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

*** Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

*** Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:
Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

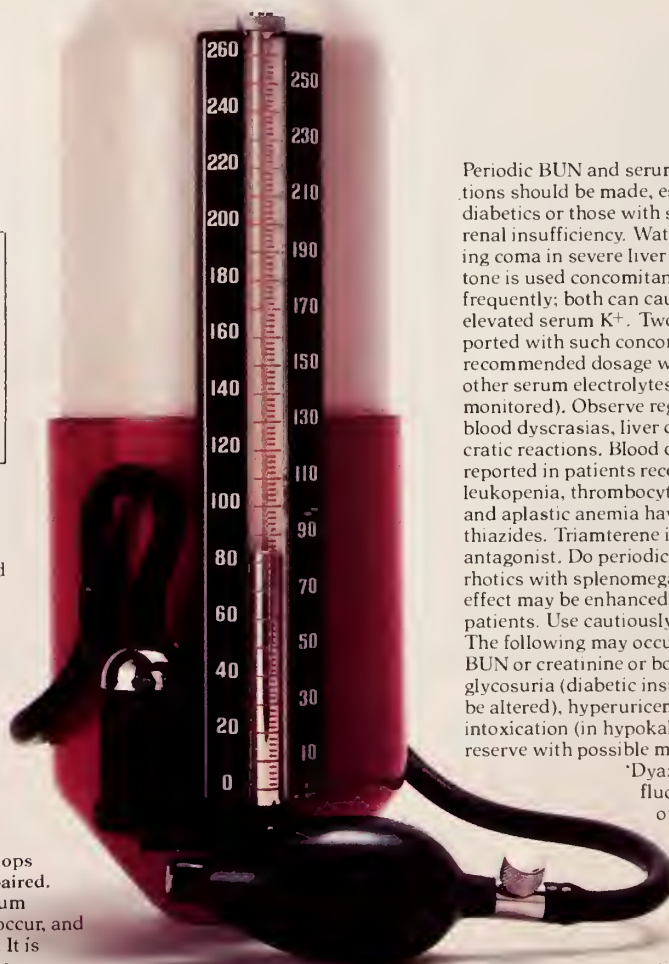
nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

**FOR LONG-TERM CONTROL
OF HYPERTENSION*
SERUM K⁺ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company



following onset of illness of the original case.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

References

1. Baine, W. B.: Bacterial Meningitis. *Current Therapy* 46-53, 1977.
2. Weekly Morbidity and Mortality Report. Vol. 25, No. 33, Aug. 27, 1976.
3. Grossman, M. and Javitz, E.: *Haemophilus influenzae* meningitis. *Current Medical Diagnosis and Treatment*, 821, 1976.

SIRS: The recommendations of the task force on blood pressure control in children are as follows:

1. Children 3-years-old and older should have their blood pressure measured annually as part of their continuing health care.
2. Hypertension detection should be incorporated into the child's total health care program; high blood pressure detection programs per se for children should not be established. Referral and follow-up resources must be identified before detection activities begin.
3. Blood pressure measurements on infants and children should be taken in a quiet environment, with the correct cuff size, and with the fourth phase Korotkoff sound used for the diastolic pressure.
4. Blood pressure measurements obtained should be recorded on appropriate blood pressure charts, and their significance should be judged accordingly.
5. Caution should be exercised in labeling children as hypertensive because of psychosocial and economic implications; use of the term "high normal blood pressure" is appropriate during evaluation and follow-up to avoid unnecessary negative implications.
6. Sustained blood pressure levels (obtained at least on three separate occasions) that are above the 95th percentile should be considered abnormal, with recognition that any cutoff point represents an arbitrary decision at any age.
7. In infants and children with sustained blood pressure above the 95th percentile, a medical history should be obtained, a physical examination performed and further tests completed as outlined in this report to determine a possible cause and to develop an appropriate follow-up program.
8. Children with sustained elevated blood pressure should receive a systematic long-term follow-up program, which may include hygienic coun-

seling covering weight control, salt intake, exercise and smoking, and anti-hypertensive pharmacotherapy when indicated.

9. Physicians who manage hypertensive children with pharmacotherapy should use the "stepped-care" approach, with emphasis on minimal effective dosages of appropriate agents.
10. Children at high risk of developing elevated blood pressure should be evaluated for other atherosclerotic risk factors and should be taught to observe necessary hygienic measures for lowering risk factors.
11. Nurses and other properly trained and supervised nonphysician health personnel should participate in the identification and management of children with elevated blood pressure.
12. Specific research in the field of blood pressure control in children should be encouraged and funded. For this purpose, guidelines for research in children should be developed, including the evaluation of new drugs and other methods of control.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

THE LITERATURE

Book Reviews

Diagnostic Pathways in Clinical Medicine: An Epidemiological Approach to Clinical Problems. By B. J. Essex. 171 pages. New York: Churchill Livingstone, 1976. \$9.95.

In his preface the author states that "the aim of this book is to provide the student with the skills needed to make an accurate diagnosis in the outpatient clinic in less than three minutes per patient." He goes on to explain that in Africa these clinics are very large and may see as many as 200 patients in a morning. The objective of this book is to suggest a system of triage for the handling of these enormous loads. Working as he does in East Africa, Dr. Essex has developed criteria for the diagnosis of diseases especially prevalent in that geographic area. In many cases, they would not be applicable to any other geographic region. Diseases of special concern include malaria, kwashiorkor, tuberculosis, schistosomiasis, hepatitis and diarrhea or dysentery.

There are introductory sections on the Causes of

LITERATURE / Continued

Disease, Disease Patterns and Outpatient Problems, Skills of Outpatient Diagnosis and Important Physical Signs. The remainder of the book is a series of "flow charts" and disease tables. The charts are grouped under the headings of General Symptoms of Disease, Pains and Irritations, Body Discharges, Symptoms of Heart or Lung Disease, Swellings and Other Physical Signs. A final section on Outpatient Management deals with decision making, referrals to a hospital, etc.

The author points out that "there is a great danger that this book will be misunderstood and misused." This is a timely warning in that it must constantly be remembered by the reader that the volume was written for a particular geographic region with a spectrum of diseases unique to East Africa and designed to be used in overcrowded clinics where time and limited facilities do not permit laboratory diagnosis or extensive clinical workups.

One difficulty encountered in the use of the book is that following each set of symptoms, the reader is referred to one or more flow charts. The symptom complexes and the flow charts are not indexed in a way that makes them easy to locate, so that one may have difficulty in matching a given set of symptoms with the appropriate diagnostic chart. In some cases, the physician must thread his way through three or four of the diagnostic charts in order to arrive at a "diagnosis." Diagnostic question number four is a case in point. The only information provided is that "a man aged 24 had symptoms of vomiting, severe abdominal pain, fever and body weakness. He had no history of recent drug treatment. The only positive findings on examination were temperature 38.8, jaundice with bile in urine, mild pain in right upper abdomen on examination." Solely on the basis of this information the physician is expected to make a preliminary diagnosis of infectious hepatitis. To confirm it he is referred to a vomiting chart which refers him to a fever chart which then refers him to a jaundice chart. Each of these charts is a page or more in length and requires careful study in order to arrive at the correct answer.

It would obviously take a considerable amount of practice to be able to use a book such as this efficiently and effectively. While it would not, as written, be directly applicable to the needs of physicians in areas other than East Africa, it does suggest an approach that might be of interest to physicians elsewhere. The amount of laboratory work called for is an absolute minimum, even for a country like Tanzania but this represents an effort by the author to

deliver the best possible care under extremely difficult situations. He points out that there are those who believe that "good medicine cannot be practiced when there is only three minutes for each patient," and that if this is true, "then it is not possible to diagnose diseases in 90 per cent of sick people and what remains is to give outpatient treatment for symptoms only, without trying to make a diagnosis."

THOMAS J. BROOKS, JR., M.D.
Jackson, MS

Lung Disease, State of the Art, 1975-76. Published by the American Thoracic Society.

This book is the second volume of a series which is printed by the American Thoracic Society. The articles are a series of "State of the Art" articles appearing monthly or bi-monthly in *The American Review of Respiratory Disease*. Volume I included 14 different articles on varying subjects, and this second volume includes 11 articles by noted authorities in areas of lung disease which have had some recent change and new methods introduced. The subject in Volume II includes silicosis, respiratory disease in coal miners, asbestos-related disease of the lungs, expression of immune mechanisms in the lungs, pulmonary infections in the compromised host (in two parts), the use of radioisotopes in pulmonary disease, connective tissue of the lungs, cystic fibrosis, bronchial asthma, bronchial provocation tests in analysis of asthma, and general anesthesia in the lung. These articles should provide physicians with concise, comprehensive, authoritative reviews of these selected topics.

This volume would probably not be too helpful to the family practitioner or any of the non-thoracic surgical specialties. However, for the hospital library, physicians interested in chest disease, and any teaching program involving medical students or respiratory therapists, this volume contains a large amount of current, useful, information.

G. BOYD SHAW, M.D.
Jackson, MS

CLASSIFIED

F.P.'s NEEDED—Growing comm. of 4000+ needs 1-2 M.D.'s 2 F.P.'s in town & 1 near by. Join exist. prac. or solo avail. Xln't rec. & econ. 60 min. from metro-cities, 57 Bed J.C.A.H. Hosp. in comm. Trade area of 12,000+ U.S. Grad. pref. Contact L. Wattier, Adm. Mem. Hosp. Inc., 104 W. 17th, Schuyler, NE 68661 (402) 352-2441.

MSMA—MHA Conduct Leadership Seminar

Hospital cost containment, consumer fear of catastrophic health costs, National Health Insurance and hospital/medical staff relationships were some of the major topics occupying the attention of physicians and hospital administrators at a "Leadership Seminar" sponsored by MSMA and the Mississippi Hospital Association in Jackson on Sept. 16.

Congressman David Bowen in a luncheon address to the seminar predicted that neither hospital cost containment or national health insurance would pass Congress this year even though national sentiment appears to exist for both. "There are more pressing priorities at this time," Bowen stated, "and the issue of national health insurance may very well be settled by passage of some type of health legislation covering children, mothers and the catastrophically ill."

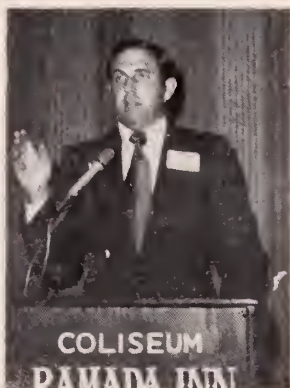
Also appearing at the meeting were Dr. John Zapp and Irwin Wolkstein, chief congressional lobbyist for the AMA and AHA respectively, who discussed current health legislation before congress. Both speakers stressed the need for "grass roots" contacts by physicians and hospital administrators with their members of congress as the best way to tell "medicine's views" on health legislation. Wolkstein related how one hospital administrator meeting with his congressman during the recent congressional recess and "... explaining how Carter's cost containment proposal would affect the local hospital" had changed the congressman's vote.

Dr. Daniel T. Cloud of Phoenix, Arizona, a member of the Joint Commission on Accreditation of Hospitals and AMA Board of Trustees, discussed hospital-medical staff relationships with the seminar participants. He stated that relationships between the medical staff, administration and governing body of a hospital were "like a three-legged stool and prob-

lems arise when the three legs disagree about their respective roles and about directing the legs to move in a coordinated manner toward the goal of improved patient care."

Paul Pittman, editor and publisher of the *Tylertown Times* and author of a weekly syndicated column appearing in over 50 Mississippi newspapers, presented a consumer's view of health issues in Mississippi. He stated that patients respected and admired their physicians, but that the profession in general had a negative image of being against everything. "The greatest fear an individual has is probably that fear of a catastrophic illness that will leave him penniless," Pittman noted.

Dr. Carl Evers, MSMA president-elect and Associate Dean at the UMC, discussed new federal scholarship and training requirements for medical students. Chandler Clover, Executive Director of the Woman's Hospital in Jackson, discussed the effect of hospital cost containment proposals. Philip Laird, director of the Mississippi Health Systems Agency, Inc., related that agency's goals to the seminar participants. And, George W. Wells, Government Relations Associate with the Health Insurance Association of America, described his organization's proposal for national health insurance and how the proposal could abate rising medical costs.



Congressman Bowen

1978 MSMA-Robins Award Nominations Are Requested

The 1978 MSMA-Robins Award will be presented to a Mississippi physician for outstanding community service during the 110th Annual Session, May 1-4, 1978. Each component medical society is invited to submit one nomination for the award by Jan. 1, 1978.

Nominations may be prepared in letter form, and there is no restriction as to attachments, exhibits, and enclosures which support the nominee. The service for which the award is made should generally be apart from achievements in medicine, since suitable awards in this connection already exist. The service need not be a single achievement; rather it

ORGANIZATION / Continued

may consist of a series of services rendered over the years to the community or state.

Nominees will be judged by the three vice presidents of the association who are designated as the MSMA-Robins Award Board of Judges. The award, a sculptured, engraved plaque on a mahogany mount, is co-sponsored by MSMA and the A. H. Robins Company of Richmond, Va., the long-established, ethical pharmaceutical manufacturer.

Societies are reminded that nominees of previous years who did not receive the award may be re-submitted. The association hopes that each component medical society will participate. All nominations will be promptly acknowledged and placed before the Board of Judges.

Medical Center Announces New Faculty Members

A professor and an assistant professor have been named to the faculty of the University of Mississippi School of Medicine.

UMC Vice Chancellor and School of Medicine dean Dr. Norman C. Nelson announced the appointments following approval of the Board of Trustees, Institutions of Higher Learning.

They are Dr. John Edmund Kiley, professor of medicine, and Dr. David Raphael Levy, assistant professor of pediatrics. Dr. Levy was also named assistant director of University Hospital's pediatric outpatient department.

Dr. Kiley earned the B.S. degree at Rensselaer Polytechnic Institute, Troy, NY, and the M.D. degree at Harvard Medical School. He did his internship at Albany Medical Center Hospital, Albany, NY, and his residency at Samaritan Hospital, Troy, NY and the Albany Medical Center Hospital.

Dr. Kiley comes to UMC from the Albany Medical Center, where he has been professor of medicine and coordinator of the clinical pathology course. He has been on the Albany faculty since 1952.

Joining the UMC faculty Sept. 1, Dr. Levy earned the M.D. degree at the University of Witwatersrand, Johannesburg, Republic of South Africa, and the M.P.H. degree at the University of California at Berkeley. He did his internship at Baragwanath and King Edwards Hospitals, Johannesburg, and his residency at Harlem Hospital Center, New York City, and Jewish Hospital Medical Center, Brooklyn, NY.

He has been medical director of the North Bay Regional Center in Napa, CA, since July, 1973.

Dr. Gilmore Visits Component Societies



MSMA President James O. Gilmore of Oxford is shown making his first component society appearance for the 1977-78 association year at a combined meeting of the Singing River and Coast Counties Medical Societies on Sept. 7.

Diagnostic Computer Is Newest UMC Teacher

The newest teacher in the University of Mississippi School of Medicine's new Department of Neurology is the diagnostic computer.

Department chairman Dr. Robert D. Currier designed the program with hundreds of questions, each with several possible answers and each answer keyed to another question, a process which eventually leads a student to a diagnosis.

It may be the only computer program in the country used for the teaching of general neurologic diagnosis.

Students work at a typewriter terminal which is hooked up by telephone to the major computer for scientific research in the Department of Physiology-Biophysics.

"The computer's diagnosis should be the same one a student arrives at from clinical observation," Dr. Currier said. "If it's not, they know they've missed something."

In the longer view, Dr. Currier hopes the computer will have wider use. "Right now it's not much use to either residents or other neurologists because it's just not smart enough," he said. "We want students, as well as physicians, to add information, make comments about the diagnosis, and correct facts as they use the program. The more physicians who use it, the smarter it will be."

With the decreasing cost of computer terminals and the economy of telephone service, he foresees a

time when physicians all over the country could have access to the growing UMC brain.

"Someday, a doctor in Hattiesburg or Cheyenne, WY, can dial the computer's number and get help with a diagnosis at 1 a.m. when other sources may be unavailable. The technology is available. We're just waiting for people to add to the knowledge bank."

Deposit Guaranty Bank Gives to Guardian Society

The Deposit Guaranty Foundation of Jackson has pledged \$5,000 to the Guardian Society of the University of Mississippi Foundation.

J. Herman Hines, chairman of the Deposit Guaranty National Bank board, presented the first \$1,000 installment of the five-year pledge to Dr. Norman C. Nelson, University of Mississippi Medical Center vice chancellor, and Dr. Stacy Davidson of Cleveland, Guardian Society chairman.

In accepting the pledge Dr. Nelson praised the foundation for setting an "excellent example" for others in the business community to follow.

"We are pleased to know the School of Medicine merits your confidence as we strive for an expanded era of excellence in education, research and service. I know of no contribution more likely to pay lasting dividends than an investment in the future of our deserving young men and women in the medical profession."

The Guardian Society was established in 1975 by the University of Mississippi Alumni Association



Dr. Stacy Davidson of Cleveland, left, chairman of the Guardian Society of the University of Mississippi Foundation, and University of Mississippi Medical Center vice chancellor Dr. Norman C. Nelson, left, accept the first \$1,000 installment of the five-year Deposit Guaranty Foundation pledge of \$5,000 to the Guardian Society from J. Herman Hines, chairman of the board of directors of the Deposit Guaranty National Bank.

Medical Alumni Chapter as a special support resource for the UMC School of Medicine.

Membership is open to medical alumni and organizations or individuals interested in actively supporting the Mississippi medical school and its development programs.

Freshman Medical Students Register at UMC



The University of Mississippi School of Medicine Class of 1981, representing 28 different colleges and universities, registered Aug. 29-30 at the Medical Center. Dr. Carl Evers, center left, associate dean for student affairs at UMC, talks with three of the 150 entering students, from left, Jan Stone of Marks, Keith Moses of McComb, and Robert Powers of Greenwood.

ACS Sponsors Cancer Control Program at UMC



Speakers for an informational program on cancer control sponsored by the American College of Surgeons at the University of Mississippi Medical Center were, from left, Dr. George V. Smith, FACS, UMC associate professor of surgery and program coordinator; Dr. Charles Floyd of Gulfport, FACS, regional vice president, American Cancer Society; Ms. Marjorie Krennerich, of Chicago, field secretary, American College of Surgeons; and Dr. Andrew Mayer of Chicago, FACS, representative of ACS. Registrants discussed setting up tumor registries and educational conferences on cancer at Mississippi hospitals.

Mississippi's First Nurse Practitioner Clinic Opens

Mississippi's first rural primary health care clinic staffed by a nurse practitioner with physician participation from nearby communities officially opened in West this summer.



Shown in front of the West Clinic at its official opening are (from left) Mayor Mary Ann Stevens; business manager, Doug Aldridge; nurse practitioner, Mary Alexander; clerk typist and LPN, Sheila Barnett; nurses' aides, Dorothy McChristian and Eunice Kirkwood; and van driver, Larry McLellan.

The West Primary Care Clinic serves a population area of approximately 3,000 people in Holmes, Attala and Carroll counties. Mrs. Mary M. Alexander, adult nurse practitioner graduate of the University of Tennessee, serves as the clinic's nurse practitioner and Dr. Arthur A. Derrick of Durant, an MSMA past president and current vice chairman



Dr. Derrick, and nurse practitioner, Mary Alexander, confer about a patient during Dr. Derrick's weekly visit to the West Clinic.



Nurses' aides, Dorothy McChristian and Irene Young, plan their daily visits to the homes of patients of the West Clinic.

of the Board of Trustees, serves as medical director of the clinic along with a staff of seven other physicians.

The West Clinic is funded by a grant from the Rural Health Initiative Program of the Department of H.E.W. RHIP is a relatively new program providing funds for staffing and operating clinics utilizing physician extendors in medically underserved areas.

Mayor Mary Ann Stevens of West got the idea to



Dr. Derrick and clinic manager Doug Aldridge, confer about medical supplies during Dr. Derrick's weekly visit to the West Clinic.

establish the West Clinic in 1975 when she "realized that we needed health services in West, but we didn't need a full-time physician."

"Most of the people in this area are over 65 and per capita income is around \$1,600," Mayor Stevens continued. "Our people were traveling all over the countryside, if they could, seeking medical

services which I felt could better and more economically be furnished here at home."

Mayor Stevens talked to Dr. Derrick about the situation and from there with the assistance of the Mississippi Regional Medical Program, the Mississippi State Board of Health, members of the Mississippi Congressional Delegation and others, the West Primary Care Clinic became a reality.

Mayor Stevens now receives many calls and visitors to West who state, "we want to do what West did!" This past month, Robert Derzon, director of the new Health Care Financing Administration of the Department of H.E.W., paid a special visit to the clinic along with other H.E.W. staff.

West's nurse practitioner, Mary Alexander, was an R.N. at the Durant Hospital when the clinic was funded by the Mississippi Regional Medical Program in 1975. Part of that funding was to send Mrs. Alexander to the University of Tennessee for training. She graduated from the UT program in 1976 after being named "most likely to succeed" by her classmates.

Mrs. Alexander's graduation didn't immediately provide the West clinic with its nurse practitioner, however, because she finished before the state was ready to license her as the state's first adult nurse practitioner.

In 1973 a joint practice committee of MSMA and the Mississippi Nurses Association had proposed that the two associations seek necessary legislation to implement an expanded role for the qualified nurse. The committee had studied programs similar to West's in other states, particularly in rural Idaho, and had concluded that the programs could beneficially serve rural areas in Mississippi.

An "expanded role" amendment to the Nursing

Practice Act was later passed by the Mississippi Legislature. Under that amendment the Mississippi Board of Nursing and Mississippi State Board of Health were to jointly adopt rules and regulations providing for the expanded role. The rules and regulations to cover a nurse practitioner like Mrs. Alexander were officially implemented in 1977 after a process of formulation by the MSMA/MNA Joint Practice Committee and approval by the Mississippi State Board of Health and the Mississippi Board of Nursing.

A typical day at the West Clinic consists of patients visiting the clinic as well as the clinic's staff visiting patients in their homes in the clinic's capacity as a Medicare certified home health care agency.

Some 90 per cent of the population served by the clinic is over 65 and the clinic is providing supportive type health services to many patients with chronic illnesses. They are at home, however, instead of in a hospital or nursing home.

Mrs. Alexander does a history and physical on each new patient following a problem oriented medical record approach. Those complaints which she cannot handle under "standing orders" are referred to a physician. Any management of a patient performed by Mrs. Alexander is also relayed to the patient's physician.

Additionally, Dr. Derrick visits the clinic every Thursday in his capacity as medical director. Finally, and probably most important, to the West Clinic's success with its clients are the words of Mrs. Alexander, "I just know the people in this area from living here and from working in the Durant Hospital."

CHARLES L. MATHEWS
Executive Secretary

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IN CONCLUSION

Hyaline membrane disease -- major cause of death in premature babies -- may be preventable, according to JAMA. Underdeveloped infant lungs produce a protein substance (fibrin strands) that grow in the lungs' tiny air sacs and prevents expansion and contraction. Roswell Park research team in Buffalo found that a single injection of plasminogen dissolves strands so the lungs can develop normally. Study of 500 infants apparently had no side effects, but human plasminogen is expensive, difficult to prepare, and unavailable for general use.

About 10 million people in 150 nonprofessional occupations are required to be licensed under nearly 2,800 existing state laws. This information emerged at a Senate Select Committee on Small Business hearing, investigating whether such practices are monopolistic. Citing the health industry as an example, S. J. Mushkin, director of Georgetown University's Public Services Lab, said there had been a proliferation of licensing and that "about one million health personnel" were licensed, in addition to physicians, dentists and nurses.

Physicians are learning more about nutrition in today's medical schools, an AMA survey has shown. The 1976 study revealed that virtually all of the nation's 114 medical schools now offer some training in nutrition. Some 19 per cent of the schools have a required course in nutrition and 70 per cent have an elective course. Increased student interest in learning more about nutrition was reported by many of the schools, according to the survey which was conducted by the AMA's Department of Foods and Nutrition.

A Comprehensive Epilepsy Service Network is being organized and the central component will be the Office for Special Neurological Impairments in the National Institute of Neurological and Communicative Disorders and Stroke. Within the network, a patient who has epilepsy will have access to a three-tier system. First level would be the physician or other community service provider who diagnoses epilepsy. Next is one of 500 regional Community Resource Persons and finally, there is the Epilepsy Family and Resource Team on the national level.

The hospital operating room staff runs an increased risk of health problems of their own, probably from chronic exposure to anesthetic gases, says a report in the Journal of the American Medical Association. Studies in the U.S. and Scotland provided data showing female physicians working in the OR have an increased risk of 26 per cent above average for spontaneous abortion and a 38 per cent greater likelihood of giving birth to a malformed infant. Men had an increased risk of liver disease and increased frequency of birth defects in their offspring.

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psycho-

tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

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November 1977

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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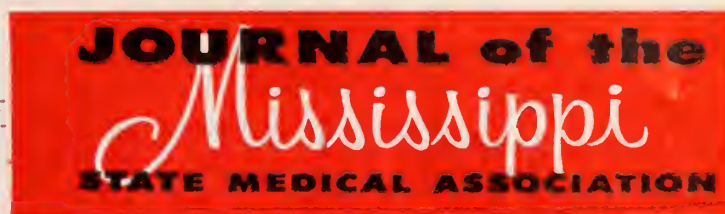
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Volume XVIII

Number 11

November 1977



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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (Publication No. 284800) is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$15.00 per annum; \$2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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Tedral SA: each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital in the immediate release layer.

Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

Tedral Elixir is convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients; porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to *one-quarter* Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

STORE BETWEEN 59° and 86°F (15° and 30°C).

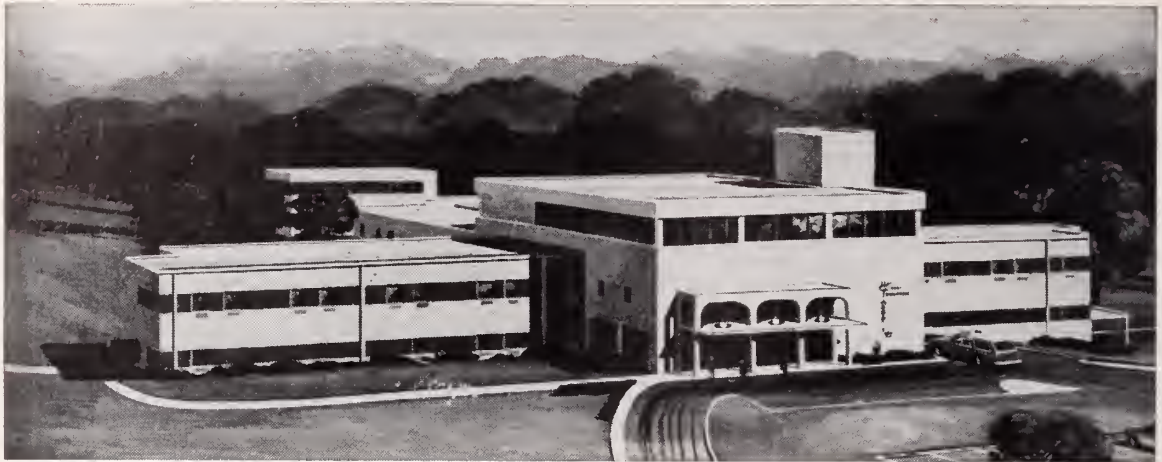
Full information is available on request.

The Child-Care Connection Is Studied

Child-care facilities have been increasingly recognized as being involved in the transmission of enteric infections, according to the State Board of Health. Outbreaks of hepatitis, shigellosis and salmonellosis, giardiasis, unspecified gastrointestinal disease, and other enteric illnesses have been linked to such institutions. The problem has attracted greater attention in recent years as the number of centers has increased dramatically. These centers are designed to provide care for the very young, ranging in age from a few weeks to four or five years. The young age of these children creates special health problems. Younger children may be especially susceptible to infection because of immature immune mechanisms. They have more numerous contacts than do children who stay at home. They have not completely learned personal hygiene practices, and may not be toilet trained, so that there is an opportunity for fecal-oral spread of disease among the children, as well as between the children and their caretakers, points out the SBH Bureau of Disease Control Director, Dr. Durward Blakey.

Working parents may be greatly inconvenienced if illness in a child results in his exclusion from the center. Parents, lacking medical knowledge, may not recognize the severity of the illness. Even if day-care workers screen children who have diarrheal illnesses and exclude them from the center, problems may arise because of asymptomatic infections. Mild illnesses due to viral hepatitis, in which jaundice does not occur, for example, are more frequent in children than adults. Transmission among children and their family members can occur despite absence of jaundice.

Public health workers should be aware of the role that child-care facilities may play in the transmission of communicable diseases. Persons with diseases which are known to be transmitted from person-to-person should be asked the following question: "Does anyone in your home, or with whom you have close contact, attend or work at a child-care facility?" Reporting of communicable diseases to both the child-care facility and the appropriate health officials should be encouraged, since early detection of disease problems may prevent further occurrence of illness and a resultant need for temporary closing of facility, said Dr. Blakey.



HILL CREST HOSPITAL

For Intensive Treatment of Psychiatric Disorders

This 101-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

ADMINISTRATOR: Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South

Birmingham, Alabama 35212

PHONE: 205-836-7201

NEWSLETTER

November 1977

Dear Doctor:

The only significant trends that have contributed to lower health care costs have been reduction in length of hospital stays and an increased tendency to treat patients with selected diseases in an ambulatory setting. This information is contained in "Changes in the Costs of Treatment of Selected Illnesses: 1951-1964-1971," the latest report published by HEW as part of its Research Digest Series on health care.

Report states that every other shift in care--such as use of tests, physician training level, nature of medical or surgical therapy--has led to increasing costs and calls findings "depressing news" that showed "we are...being nicked and dimed to death, except that the nickels and dimes are five-, ten-, and twenty-dollar bills."

MSMA president, Dr. James O. Gilmore of Oxford, received the following telegram from James H. Sammons, AMA Executive Vice President: "Congratulations and Bravo! According to our records, as of September 23, 1977, MSMA exceeded its 1976 year-end total for AMA dues paying members. Thank you for your participation and support; only 12 other states have accomplished this same feat."

Alabama, Iowa, and Wisconsin have recently become the thirty-fifth, sixth, and seventh states to enact certificate of need statutes. The Alabama law defines "health care facilities," which are subject to the certificate of need requirements to specifically exclude "the offices of private physicians or dentists, whether for individual or group practices, and regardless of ownership."

Eight months after publication of an error-ridden list of physicians supposedly receiving substantial Medicare payments in 1975, the government has published a corrected list of physicians receiving large Medicare sums. HEW officials said recently that present plans are to prepare next time a listing of all physicians receiving any Medicare payments in 1976. Cost of list is some \$300,000 annually.

No clinical trials for laetrile now, says the National Cancer Institute. Instead, NCI, Center for Disease Control and FDA specialists are discussing protocol for study of people already using laetrile. "We felt it would be inadvisable to go ahead on a clinical trial at least until we had made the effort to see whether we could in fact document whether there are bonafide (cancer) regression," said NCI.

Sincerely,



Nola Gibson
Managing Editor

Use of Laetrile Is on the Wane

An analysis of the laetrile phenomenon by the *New York Times* shows that support for the alleged anticancer compound has waned. Eleven states with a total population of 37 million have enacted laws permitting intrastate production and distribution of laetrile. However, the pace of passage seems to have peaked. The bill is stalled in California, Illinois, Michigan, Pennsylvania, and in New York, where the governor said he would veto any such legislation because it smacks of cancer quackery.

Three leaders of the laetrile movement recently dimmed their chances to gain national support when, before a Senate subcommittee, they resorted to statements asserting that an international conspiracy was preventing the cure of cancer.

On the House side, the Commerce Committee health subcommittee has pigeonholed a bill that would have the effect of removing the federal ban on laetrile. The FDA has reaffirmed its hard line against the compound, and federal agents have raided laetrile factories in four states. Meanwhile, the Mexican government, which has sanctioned the use of laetrile, has shut down one of the two main production factories in Tijuana, charging that the plant was unsanitary.

Society of Cardiovascular Radiology Meets in New Orleans

The Society of Cardiovascular Radiology announces its Third Annual Postgraduate Course on Diagnostic and Therapeutic Angiography and its Relationship to Other Imaging Modalities, to be held at the Fairmont Hotel in New Orleans, Feb. 20-23.

The material to be covered includes daily symposia on the relationship of angiography to other imaging modalities, problems of thromboembolic disease, clinical applications of venous sampling, and interventional angiography. In addition, eight student participation workshops will be held each afternoon covering specific technical and clinical problems in angiography.

The course is approved for 24 hours of Category I Credit by the American College of Radiology and the American Medical Association.

The tuition fee of \$275.00 includes luncheons with the faculty and coffee breaks, \$175.00 for residents and fellows. For further information and application blanks contact: William J. Casarella, M.D., Department of Radiology, Columbia-Presbyterian Medical Center, 622 West 168th Street, New York, NY 10032.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)

ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

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**When you're good
people recognize you.**

Highly effective
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Pleasant tasting

Antiminth[®]
(pyrantel pamoate)

equivalent to 50 mg pyrantel/ml
ORAL SUSPENSION



a drug of choice in
pinworm infections

Please see brief summary of prescribing information on facing page.

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BREATHING WITH COMFORT.

Choledyl — a highly soluble, true salt of theophylline — rapidly relaxes bronchospasm to promote easier breathing. And, gastric discomfort is minimal.

Because Choledyl is more stable...more rapidly absorbed from the G.I. tract than aminophylline.

Available in both tablets and elixir for patients with obstructive lung disease.

Choledyl® (oxtriphylline) Tablets and Elixir CAUTION: Federal law prohibits dispensing without prescription. Each partially enteric coated tablet contains 200 mg or 100 mg oxtriphylline. Each teaspoonful of the elixir contains 100 mg oxtriphylline; alcohol 20%. **Indications.** Choledyl (oxtriphylline) is indicated for relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema. **Warning.** Use in pregnancy — animal studies revealed no evidence of teratogenic potential. Safety in human pregnancy has not been established; use during lactation or in patients who are or who may become pregnant requires that the potential benefits of the drug be weighed against its possible hazards to the mother and child. **Precautions.** Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children. **Adverse Reactions.** Gastric distress and, occasionally, palpitation and CNS stimulation have been reported. **Dosage.** Average adult dosage: Tablets — 200 mg, 4 times a day; Elixir — two teaspoonfuls, 4 times a day. **Supplied.** 200 mg yellow, partially enteric coated tablets in bottles of 100 (N 0047-0211-51) and 1000 (N 0047-0211-60); Unit Dose — 200 mg tablets (N 0047-0211-11); 100 mg red, partially enteric coated tablets in bottles of 100 (N 0047-0210-51). Elixir — bottles of 16 fl oz (1 pint) 474 ml (N 0047-0215-16). **Toxicity.** Oxtriphylline, aminophylline and caffeine appear to be more toxic to newborn than to adult rats. No teratogenic effects have been seen. Full information is available on request.

CH-GP-51-4/C



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CHOLEDYL®

(OXTRIPHYLLINE) SINGLE-ENTITY
BRONCHODILATION
MINIMAL GASTRIC DISCOMFORT

Baptist Med Center Holds Cardiovascular Seminar

Mississippi Baptist Medical Center conducted its third annual seminar on cardiovascular medicine and surgery Sept. 9-10 at Holiday Inn Downtown in Jackson.

Dr. Robert B. Wallace, chairman of the department of surgery at Mayo Clinic, Rochester, MN, and professor of surgery at the Mayo Medical School, University of Minnesota, and Dr. Lawrence S. Cohen, professor of medicine and chief of cardiology at Yale University School of Medicine, New Haven, CT, were the guest faculty.

Also participating were Dr. H. Davis Dear, director of the cardiovascular laboratory at Mississippi Baptist Medical Center; Dr. Thomas L. Kilgore, Jr., MBMC division of cardiovascular surgery; Dr. Martin H. McMullan, chief of surgery at MBMC; Dr. McKamy Smith, director of the MBMC cor-

onary care unit; and Dr. Morris Williams, chief of the cardiology section, MBMC.

A special speaker at the noon luncheon on Friday, Sept. 9, was Owen Cooper, Yazoo City, retired president of the Mississippi Chemical Company. Cooper, himself a former cardiac patient, is past president of the Southern Baptist Convention and vice-president of the Baptist World Alliance.

Dr. Wallace, prominent in the field of cardiology training and surgery, discussed surgical experience with coronary artery disease at the Mayo Clinic and aortic valve replacement.

Dr. Cohen's topics included identification and evaluation of patients with coronary artery disease, natural history of valvular heart disease, and beta adrenergic blockers.

The two-day program also included discussion of electrocardiography, surgery of the abdominal aorta, management of low cardiac output states, atrial myxoma, risk factors and coronary artery disease, and exercise following myocardial infarction.

MARCH 31-APRIL 4, 1978

41st Annual

New Orleans Graduate Medical Assembly

Fairmont Hotel, New Orleans

Meeting Theme: "The High Risk Patient"

Accreditation: AMA, Category I—AAFP, Acep. Category I

Adolph A. Flores, Jr., M.D., *President*

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New Orleans 70112

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consider the effect on coexisting diabetes when you prescribe a vasodilator*



(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the diabetic patient has been reported with

VASODILAN® (ISOXSUPRINE HCl) the compatible vasodilator

TABLETS, 20 mg.

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Mead Johnson LABORATORIES

DATELINE

Medical Record Data New York, NY - As reported in the September issue of
Centers Are Accredited Privacy Journal, representatives of the Medical Society
of New York, Blue Cross/Blue Shield, professional standards
review organizations and various other New York professional and insurance organi-
zations, recently met to form a corporation to accredit data centers operating in
New York which handle personally identifiable medical data in order to assure
that such centers meet certain specified standards.

MSMA Announces 1978 Jackson, MS - Based on actions of the House of Delegates,
Legislative Program MSMA has announced a 1978 legislative program to: (1)
increase Medicaid payments for physicians' services;
(2) provide for yearly instruction in health education in all public schools;
(3) prohibit discrimination on the basis of age in employment practices; and
require that all malpractice claims be screened by a panel composed of one attorney
and three physicians.

Most Doctors Drive Chicago, IL - Popular belief that most doctors drive
Smaller Cars Lincolns or Cadillacs may be wrong. Some two-thirds of
American physicians surveyed in an AMA poll make their
practice rounds in intermediate, compact or economy cars. Two out of five of
the responding physicians say they have bought a new professional car in the past
two years. Three out of five are driving cars two or more years old. Two-
thirds say they have bought cars that are more economical to operate.

FDA Spot Checks Washington, DC - The U.S. Food and Drug Administration
Animal Test Results plans to become more directly involved in animal testing
that helps establish the safety of drugs and food additives,
Commissioner Donald Kennedy has announced. He said that while FDA wouldn't repeat
all the animal tests made by the companies, it could conduct a limited number of
spot checks--actually repeating some experiments in its own labs to provide a more
effective check on the accuracy and adequacy of private tests.

AMA Convention Plans Chicago, IL - The AMA will use a satellite to transmit
Satellite Telecast selected programs from the winter scientific meeting in
Miami to physicians at 35 hospitals in 11 states on the
other side of the country. The event will mark the first time anywhere in the
world that a major medical meeting of multidisciplinary scope will use the power
of satellite technology to provide continuing medical education. Physicians in
western states will gather at VA and private hospitals to watch on Dec. 12.

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the real
thing**



70-37

**Mississippi Council of
Coca-Cola Bottlers**

JCAH Requires Utilization Review

The Joint Commission on Accreditation of Hospitals (JCAH) has published guidelines that will require utilization review of all hospital patients in JCAH approved hospitals.

In new standards effective September 1977, JCAH states that the goal of each hospital's utilization review program should be "to determine that the optimal achievable quality of patient care is being provided in the most efficient manner possible."

"Utilization review," the JCAH states "is of particular importance to a hospital's surgical staff because such a review helps to identify patterns of surgical practice and to determine the necessity of surgical procedures."

The utilization review program will apply to all patients, regardless of payment source, and include review of the medical necessity and appropriateness of admissions, continued days and supportive services.

Some 70 Mississippi hospitals are presently JCAH approved. The JCAH is a voluntary accrediting source formed by the American College of Surgeons, American Medical Association, American Hospital Association and American College of Physicians in 1952.

Medicaid Reports Physician Payments

Recent data released by the Mississippi Medicaid Commission reveals that most Mississippi physicians received less than \$10,000 in payments from the program last year.

Of 2,037 physicians receiving payments, 1,596 received less than \$10,000 in payments for services rendered Medicaid recipients and 1,288 of those received less than \$5,000 in payments.

Medicaid annually reports gross payments to physicians and other health providers. National studies show that an average of 30-40 per cent of office-based physicians' gross income goes into office and practice expenses.

DISTRIBUTION OF PHYSICIAN PARTICIPATION BY DOLLARS RECEIVED

<i>Dollar Range</i>	<i>Number of Physicians</i>
Less than 500.00	502
500.00 to 5,000.00	786
5,000.00 to 10,000.00	308
10,000.00 to 20,000.00	244
20,000.00 to 30,000.00	101
30,000.00 to 40,000.00	45
40,000.00 to 50,000.00	17
50,000.00 to 75,000.00	21
75,000.00 to 100,000.00	7
More than 100,000.00	6
Total	2,037



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An efficient medical practice requires sound business management. By applying proven management techniques, you can improve the efficiency and profitability of your practice and--most important of all--have more time to devote to your patients.

These AMA Practice Management Publications, developed with the help of medical management consultants, are designed to provide you with the latest techniques and procedures in the management of your practice. Whether you are a new physician who must make immediate decisions about setting up your practice or an established physician who wants to increase the efficiency of your practice, these publications are an invaluable source.

TO ORDER: Write Order Department, American Medical Association, 535 N. Dearborn, Chicago, IL. 60610. Please specify title, OP number, and include payment with your order.

Publications

1 **The Business Side of Medical Practice** (OP-410) \$2.00

Guide to basic management principles. Includes: deciding how to practice; selecting a location; setting up an office; financing; legal hurdles; insurance; mechanics of providing good medical service; billings and collections; human relations.

2 **Planning Guide for Physicians' Medical Facilities** (OP-439) \$2.00

Provides guidelines and general principles to help you determine the criteria for selecting a medical office that best suits your needs. Includes: basic planning before building; office construction, inside and out; your office interior; office condominiums.

3 **Medicolegal Forms with Legal Analysis** (OP-109) \$1.25

Contains medicolegal forms, with legal analysis and citations of court decisions, for the more common interactions between patients and their physicians and hospitals, such as: consent and informed consent; patient's right to privacy; confidentiality of records; physician-patient relationship.

4 **Preparing a Patient Information Booklet** (OP-441) \$.30

A guide for preparing a general information booklet for your patients on your specialty and type of practice.

5 **Talking with Patients** (OP-450) \$.30

Provides proven psychological principles and specific examples on how to improve office-patient relations in telephone communications.

6 **Medical Collection Methods** (OP-448) \$25.00

A "how to" cassette/workbook program designed to train medical assistants in the most effective collection techniques.

Extra Workbooks (OP-449) \$2.00 each

7 **Professional Corporations in Perspective** (OP-102) \$3.25

1977 publication which features: economic factors, advantages and disadvantages of incorporation; effect of ERISA on professional corporations; choosing a retirement plan; and managing a professional corporation.

8 **New Doctor's Kit** (OP-458) \$10.00

Contains: **The Business Side of Medical Practice**; **Planning Guide for Physicians' Medical Facilities**; **AMA Publications Lists**; **Group Practice Guidelines**; **Current Procedural Terminology** order form; Uniform Health Insurance Claim Form; **Medicolegal Forms**; **Talking with Patients**; **Preparing a Patient Information Booklet**; AMA membership information; Placement Service; and bibliography on billing systems, recording keeping systems, etc.

9 **Group Practice Kit** (OP-457) \$7.50

Contains: **Group Practice Guidelines**; **Professional Corporations in Perspective**; medicolegal reprints on such subjects as: professional liability, confidentiality, informed consent, etc.; samples of model legal agreements for a physician and employed associate, office sharing, medical partnerships, and forming a corporation.



"...Sleep that knits up the ravell'd sleeve of care..."

—WILLIAM SHAKESPEARE, *MACBETH*, ACT II, SC. 2

Insomnia

a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin[®] (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime! Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO. Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information

ADAPIN[®] (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdose.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response.

Usual optimum daily dosage is 75 mg to 150 mg per day, not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg and 50 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.

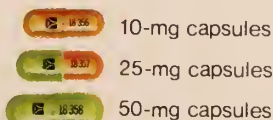


When they see life
in shades of blue...
help them see life
in all its colors.

Adapin[®]

(doxepin HCl)

single daily dose recommended h.s.



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THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® chlordiazepoxide HCl/Roche 5mg, 10mg, 25mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

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tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

ship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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H.E.W. Issues Hospital Rationing Guidelines

The Department of H.E.W. has published national guidelines for planning of hospital facilities under Public Law 93-641, the National Health Planning and Resources Development Act. The guidelines are subject to public comment and will become effective in final form 60 days from Sept. 23. They are to be implemented in each health service area within five years. Mississippi is presently a single health service area.

Under the guidelines, hospital bed population ratios will be required to be from 3.7 to 4.0 beds per 1000 population in a health service area. An exception would be made in rural areas where a majority of residents in the area would be more than 45 minutes from a hospital. Additionally, hospitals would be required to have an annual occupancy rate of at least 80 per cent.

Hospitals in Standard Metropolitan Statistical Areas, with populations of 100,000 or more (i.e. Jackson and the Gulf Coast) offering obstetrical services will be required to have at least 2,000 deliveries annually. Hospitals offering obstetrical services in other areas will be required to have 500 deliveries annually except in the case of a unit serv-

ing areas where travel time exceeds 45 minutes. Average annual occupancy rates for obstetrical units must be at least 75 per cent.

Hospitals offering pediatric services will have a minimum of 20 beds except in a case where travel time exceeds 30 minutes. Average annual occupancy for a facility with 20-39 beds should be at least 65 per cent; a facility with 40-79 beds, at least 75 per cent, and facilities with 80 or more beds at least 80 per cent.

Neonatal intensive care beds will not exceed 4 per 1,000 live births per year in a defined neonatal service area and will contain a minimum of 20 beds.

Other hospital services addressed by the guidelines include CAT scanners, heart units, cardiac catheterization units and radiology. CAT scanners should operate at a minimum of 2,500 patient procedures a year and no new CAT scanners approved unless each scanner in the health service area is performing more than 4,000 procedures a year.

A minimum of 200 procedures should be performed annually in any institution in which open heart surgery is performed and no new open heart units are to start up unless each existing or previously approved unit in the health service area is handling at least 350 cases a year.

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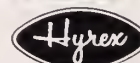
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The effect of the guidelines on Mississippi hospitals was under study as JOURNAL MSMA went to press. Two significant facts at this time are that based on apparently debatable statistical information developed by the Mississippi Health Systems Agency, Inc., Mississippi presently has 4.97 hospital beds per 1,000 population and only 12 of the state's some 116 hospitals had occupancy rates exceeding 80 per cent in the years 1974-76.

The VA System Is Criticized

The Veterans Administration's health care system should be integrated with community facilities throughout the nation, according to the National Research Council of the National Academy of Sciences.

This principal recommendation in the council report followed an intensive three-year, \$6-million study initiated by congressional mandate. The study is believed to be the first comprehensive evaluation of a large segment of the health care system in the United States.

The report contends that the VA system of 1971 hospitals and 218 clinics "is suffering partly from changing times and demands, and partly from inappropriate management policies."

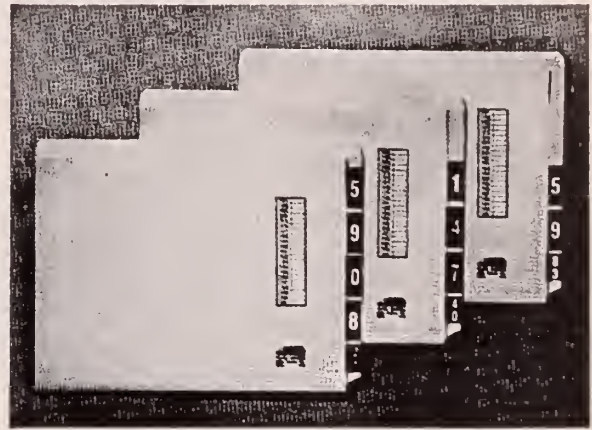
The council states that further changes are likely to plague the VA soon. Among them will be the inevitable aging of the VA patient population, whose needs for long-term care will almost triple in the next 20 years. Such needs will call for better geriatric and rehabilitative care programs, the report said.

VA Administrator Max Cleland denounced the report and said the VA would strongly resist any move to merge VA health facilities with the remainder of the nation's health care system.

The council report will undergo scrutiny at hearings this fall by Senator Alan Cranston's (D-CA) Committee on Veterans' Affairs.

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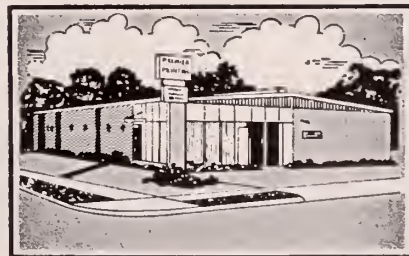
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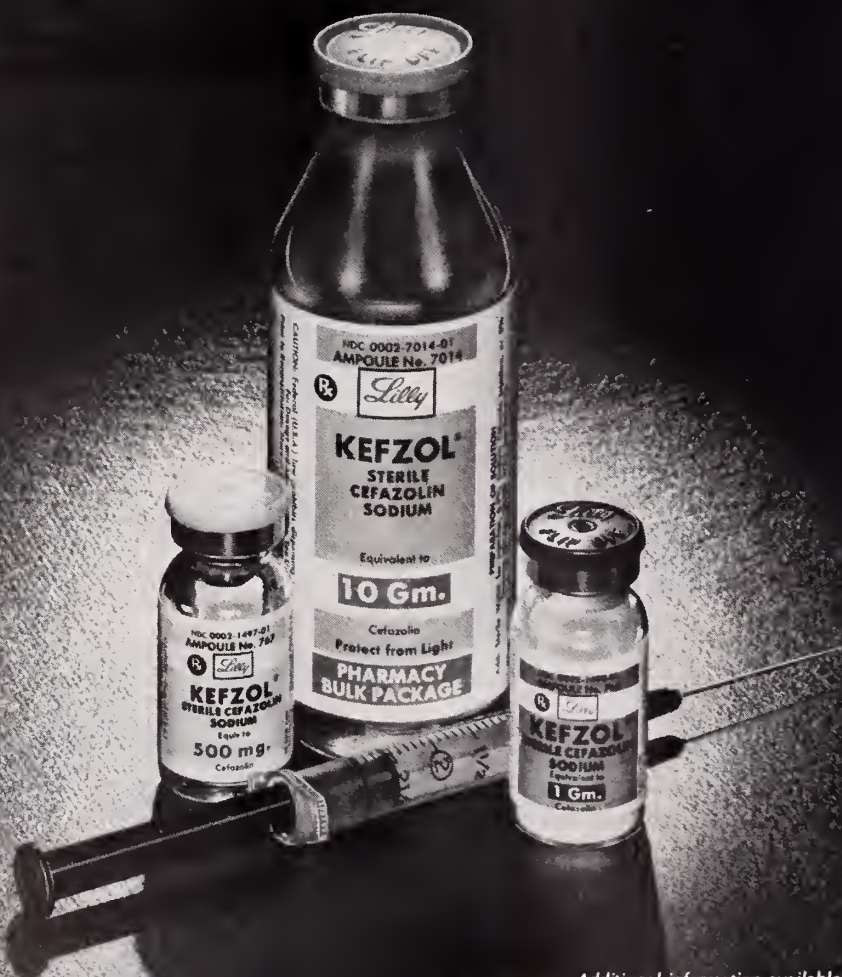
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ORIGINAL PAPERS

The Relation of Nodular Goiter to Malignancy

W. HOWARD KISNER, M.D., and H. VANN CRAIG, M.D.

Natchez, Mississippi

A RECENT NEWS media report of increased cancer of the thyroid gland in persons subjected to irradiation of the neck in childhood has prompted a number of patients to seek information from their physician. For this reason a review of nodular goiter and the relation to carcinoma with a discussion of present day therapy is presented.

Incidence

In order to separate the solitary nodule from multinodular goiter, cases presenting clinically with a solitary nodule but with more than one nodule at operation were reclassified multinodular goiter. Also cases that grossly appeared to have a solitary nodule but on pathological examination were reported to have other nodules were recorded as multinodular goiter. The authors feel an attempt should be made clinically to separate solitary from multinodular goiter because of the difference in the clinical course of the disease. Warren and Meissner¹ point out that the nodules of adenomatous goiter are easily confused with true adenomas and differentiation from actual tumor, benign or malignant, may be difficult pathologically, as well as clinically. According to our surgical records at the Natchez Medical Clinic, there were 123 solitary nodules of the thyroid gland and 83 multinodular goiters. Goiter is not endemic in the Gulf states; therefore, the disease poses problems different from that in an endemic area such as the Great Lakes region. Crile² states that from a pathologic standpoint nearly all women over 50 years of age in the Great Lakes area have nodular goiters and from a clinical standpoint nearly 10 per cent of them have palpable nodules in the thyroid gland. Behrs³ states that only 10 per cent of nod-

ular goiters seen at the Mayo Clinic are selected for surgery. Thyroid nodules are frequently found on routine examination with the patient unaware of the

The authors give a review of nodular goiter and the relation to carcinoma. They discuss incidence of nodular goiter, pathology, relation to malignancy, natural course of nodular goiter, diagnosis and treatment, and present their study of 123 cases of solitary nodules and 83 patients with multinodular goiters.

presence of a nodule. Since the majority of goiters occur in females, many of our cases were found on routine examinations by members of our obstetrical and gynecological department.

Pathology

The classification of benign adenomas by Shields, Warren and Meissner¹ is preferred by the authors. See Table I. Benign adenomas arise from the follicular epithelium and have a capsule.

A hot nodule on scan may be both malignant and hyperfunctioning. A cold nodule may be a cystic adenoma or it may represent a malignant lesion. The assumption that hot nodules as outlined by scintiscan never harbor cancer has been disproved by Meadows and others.⁴ In our series of solitary adenomas there were 65 colloid or adenomatous nodules, 32 follicular adenomas, 2 papillary adenomas, 7 fetal adenomas, 4 Hurthle cell and 2 embryonal adenomas. Eleven of these solitary nodules were malignant tumors. Warren and Meissner's¹ classification for thyroid carcinoma has been adopted by most surgeons. See Table II. In addition to the above classification, many malignant lesions are a

From the Surgery Department, Natchez Medical Clinic, Natchez, MS.

mixture of papillary and follicular. Six of our malignant cases were papillary; two were mixed papillary and follicular; and three were follicular.

The autoimmune nature of chronic thyroiditis has been known for some time. Several of the benign adenomas in our series had lymphocytic thyroiditis adjacent to the nodule microscopically and one of our cases of malignancy occurring in a solitary adenoma, a mixed papillary and follicular carcinoma, was surrounded by diffuse thyroiditis. The relationship of thyroiditis to thyroid cancer has been noted by Hirabayashi and Lindsay.⁵ They studied 436 patients with thyroid carcinoma at the University of California hospitals and found 65 per cent of papillary carcinomas showed thyroiditis in the neoplasm, the gland or both. Thyroiditis was less frequent or absent in other types of thyroid carcinoma. Hirabayashi and Lindsay⁵ also found consistently higher survival rates in both thyroid carcinoma and thyroiditis as compared to thyroid carcinoma alone. These authors' data suggest that chronic thyroiditis may occur secondary to the presence of thyroid carcinoma in many instances. Warren and Meissner¹ also agree with this opinion. Hashimoto's thyroiditis is not infrequently diagnosed as a nodular goiter; therefore, it is well to keep in mind the frequent association of malignancy and thyroiditis.

TABLE I
BENIGN ADENOMAS

1) Follicular
Subclassifications
a. embryonal
b. fetal
c. Hurthle cell
d. simple
e. colloid
f. atypical
2) Papillary
Synonyms-papillary adenocystoma and cyst adenoma.

TABLE II
CLASSIFICATION OF CARCINOMA
OF THE THYROID

Carcinoma
1) Papillary adenocarcinoma
2) Follicular carcinoma
a) clear cell carcinoma
b) oxyphil carcinoma
3) Medullary carcinoma
4) Undifferentiated carcinoma
5) Epidermoid carcinoma
6) Other malignant tumors
lymphoma, sarcoma, malignant teratoma, secondary tumors.

Russell et al⁶ at the M. D. Anderson Hospital in a study of 80 thyroid glands containing carcinoma found that 87.5 per cent of the tumors extended into the isthmus, the opposite lobe, the pericapsular lymph nodes of the opposite lobe or 2 or 3 of all these structures. These authors state the malignancy metastasizes from the primary site to all parts of the gland through the intraglandular lymphatics. The lymph vessels then carry the malignant cells to the pericapsular lymph nodes from which they pass into the cervical lymph nodes.

Relation to Malignancy

As early as 1924 Allen Graham⁷ called attention to the potential danger of the solitary adenoma of the thyroid gland. Lahey,⁸ Anglem,⁹ Cole¹⁰ and others found a high incidence of carcinoma in solitary nodules of the thyroid. The incidence of carcinoma in a solitary nodule of the thyroid varies from 9 per cent to a high of 24.5 per cent in various reported series. The incidence in our series was 8.9 per cent. This high incidence becomes more marked in the younger age group. The youngest patient in our series was 11 years of age and the oldest 54 with an average age of 28. Duffy and Fitzgerald¹¹ reported 28 cases of cancer of the thyroid in children in 1950. The initial finding in 10 of these cases was one or more enlarged cervical lymph glands with no palpable abnormality in the thyroid gland itself. Duffy and Fitzgerald¹² caused increased interest in childhood thyroid cancer with the report that 10 out of 28 cases had been irradiated during infancy for an enlarged thymus gland. Winship and Rosvoli¹³ collected 562 cases of childhood thyroid cancer. Thirty-eight per cent of their series of patients had received irradiation in infancy and early childhood. Children have been irradiated for so-called "enlarged" thymus, hypertrophied tonsils and adenoids, hemangiomas, nevi, acne and other benign lesions. Winship¹³ estimates that 20 to 52 per cent of the thyroid nodules prove to be malignant in children. DeGroot and Paloyan¹⁴ in a series of 50 patients with thyroid carcinoma found 20 who had received prior neck x-ray treatment.

In contrast to the high incidence of carcinoma in solitary nodules, there is a relatively low incidence in multinodular goiter. In the authors' series there were 2 cases of carcinoma in 83 patients with multinodular goiter or an incidence of 2.4 per cent. Cole¹⁰ reported 9.8 per cent malignancy in multinodular goiters. C. G. Thomas, Jr.¹⁵ states there are not sufficient supporting data to indicate a clear advantage for prophylactic thyroidectomy for all multi-

nodular goiters on either a theoretical or practical basis. Others feel that removal of a multinodular goiter primarily to eliminate the possibility of malignancy is not justified. The authors agree with this concept.

Natural Course of Nodular Goiter

Considerable discussion can still be generated in any panel composed of surgeons, pathologists and internists on whether carcinoma originates in a pre-existing solitary adenoma as advocated by Graham,⁷ Lahey⁸ and others or the lesion is a cancer from the beginning as advocated by Crile.² Recently (1973) Iida¹⁶ in a study of a large series of thyroid adenomas in Japan, demonstrated that an adenoma of the thyroid may stay as a solitary adenoma, undergo cystic degeneration or develop to cicatrization. The possibility of malignant degeneration appears to be present in each of these forms. As a rule both solitary nodules or true adenomas and multinodular or adenomatous goiters are slow growing and asymptomatic with many of the former being found on careful examination of the thyroid gland. Huge goiters such as are seen in the mountains of China are rare and in general the population has been unconcerned about the relation of cancer and goiter until the previously mentioned news media report alerted a number of people to this fact. As a cause of death carcinoma of the thyroid seems almost insignificant when compared to lung cancer or traffic accidents.¹⁵ In the United States carcinoma of the thyroid has been estimated to be responsible for one half of one per cent of all clinical cancer, to have an incidence of 25 patients per million population and to account for approximately 1,000 deaths annually. The authors feel that a multinodular goiter although slow growing is a continuing disease and will eventually result in symptoms in many cases.

Diagnosis and Treatment

Careful examination of the thyroid gland will usually differentiate solitary adenoma from multinodular goiter. We found a number of our cases of solitary adenoma on routine examination of patients who were unaware of the presence of a goiter. Work-up should consist of routine chest x-ray to rule out substernal goiter, thyroid function tests to determine if the patient is in a euthyroid state and in recent years thyroid scans have been routinely performed. Several of our solitary adenomas and multinodular goiters were hyperthyroid. Before surgery, these were brought to a euthyroid state with the use of anti-thyroid drugs. Hyperthyroidism is far more common in multinodular goiter and this was the case in our

series; 8.4 per cent of the multinodular goiters were toxic and only 1.6 per cent of the solitary adenomas were toxic. The scintiscan is of value to reveal unsuspected nodules and in the patient who refuses surgery or in whom, for reasons of poor health surgery is deferred. The hot nodule is of some comfort to both patient and physician, although as previously stated the cold nodule can be a cystic adenoma whereas a hot nodule may harbor carcinoma.

One of our recently operated on solitary adenomas was of interest. The mother was concerned about her daughter having thyroid cancer after seeing the previously mentioned news report. This young lady had had prior irradiation of the neck during childhood. The patients' physician was certain he could palpate a nodule in the upper lobe of the thyroid gland whereas two other physicians including one of the authors could not be sure a nodule was present. A scan revealed a well defined nodule in the upper left lobe of the thyroid gland that proved at operation to be a benign fetal adenoma. A scan of the thyroid in the authors' opinion is of little value in ruling out cancer in a multinodular goiter as both cold and hot nodules may be present in the same gland.

Needle biopsy has been advocated by some but the authors have had no experience with this method of diagnosis. The safety of thyroid surgery in competent hands plus the increased amount of tissue available for study by the pathologist makes this a more rational approach to the problem. There have been no nerve injuries and no permanent hypoparathyroidism in our series of cases. Several of the benign multinodular goiters had transient postoperative hypoparathyroidism. Trying to differentiate malignant from benign adenomas on palpation alone is risky business. Three of our solitary adenomas appeared to be benign lesions following removal at surgery. The adenomas were soft and on cut surface had a cystic necrotic appearance. The frozen section report was benign adenoma but on fixed section the final report was carcinoma. All three of these cases were taken back to surgery at a later date and a total thyroidectomy performed.

Pain, discomfort, hoarseness, dysphagia or fixation to overlying soft tissue are all signs and symptoms of advanced cancer of the thyroid gland. Colcock¹⁷ has stated the only sign or symptom of cancer of the thyroid at a time when there is an excellent chance for a cure is the presence of a nodule in the thyroid, particularly in a solitary nodule. Treatment of nodular goiter differs from one extreme to another and there is still a great deal of discussion concerning the proper care of these lesions. Astwood

et al¹⁸ believed a trial of desiccated thyroid should be resorted to in the presence of a solitary nodule. These authors state that thyroid nodules and simple goiter were reduced in size or disappeared in two-thirds of their cases. Cassidy on a panel discussing management of thyroid nodules at the annual meeting of the American Thyroid Association in Birmingham, AL, Oct. 12, 1971, stated that all nodules of the thyroid should be treated with thyroid hormone and that surgery has no place in the treatment of these lesions. He also was of the opinion that surgery may disseminate a mild carcinoma of the thyroid gland. The authors do not agree with this opinion. Surgeons in the area of endemic goiter feel that a selective approach should be made for surgery cases. A solitary nodule in a young person, rapid growth of a nodule and a strong history of cancer in a family are some of the criteria for selection of surgery cases.

Mississippi and Louisiana, home of our patients, constitute a non-endemic goiter area and we feel that all nodular goiters, provided the patient's general health and age will permit, should have surgery. Multinodular goiter, in our opinion, is a continuing disease and in many instances will eventually cause pressure symptoms, cosmetic problems or the insidious onset of hyperthyroidism and cardiac problems because of the insidious nature of the disease. We do not feel removal of a multinodular goiter is a prophylactic for cancer and the operation is best avoided in the aged patient with no symptoms. This latter may not be entirely the best policy. One of the authors of this article rejected for surgery an 85-year-old frail female with a large multinodular goiter and some deviation of the trachea. This patient lived to be almost 100 years old and never failed to scold the surgeon for not removing her goiter when she was a young 85 years. We are in accord with Colcock¹⁷ who advises any patient with a solitary nodule or a multinodular goiter of significant size to have it removed. This is true whether the solitary nodule is large or small, hard or firm, growing or not, whether the patient is 15 or 50, male or female, whether the scan shows the nodule to be cold, cool, lukewarm or hot. Our experience with suppression therapy using thyroid hormone as advocated by Astwood¹⁸ and his coworkers has been disappointing and we have abandoned this type of therapy. We believe all solitary nodules in the young should be removed because of the increased frequency of carcinoma in the young. Solitary nodules in the older patients

should be removed but the urgency is not as great as in the young.

Wide excision of an adenoma should be carried out and if the frozen section reports the presence of carcinoma, total lobectomy on that side with the removal of the isthmus and the opposite lobe should be carried out. In the early days of our series subtotal thyroidectomy or hemithyroidectomy was performed. Influenced by the report from the M. D. Anderson group^{6, 19} showing involvement of the opposite lobe in a high percentage of cases of thyroid cancer, the authors have performed total thyroidectomy since 1966. Prior to 1966, as previously stated, hemithyroidectomy was performed on several cases and subtotal thyroidectomy in two. In one case in which total thyroidectomy was performed two tiny normally appearing lymph nodes lying below the lower pole of the uninvolved lobe were removed and to the surprise of the operator both were reported by the pathology department as containing metastatic carcinoma. Total thyroidectomy was followed in one case by I¹³¹ in order to determine the presence of any functional thyroid tissue. One case of total thyroidectomy was followed with cobalt therapy. The remaining cases of total thyroidectomy including the previously two mentioned have all been treated with thyroid hormones postoperatively. The other cases including the hemithyroidectomy and subtotal thyroidectomy cases have not routinely been given thyroid hormone postoperatively. Radical neck dissection was not done in any of our cases and we do not believe that radical resection should be done unless palpable nodes are present. Total thyroidectomy is not without danger and many surgeons are becoming less radical in their approach to this problem. Clark¹⁹ reported 12.8 per cent of his patients had permanent tetany. These authors believe the advantage of total thyroidectomy outweighs these risks. Thompson and Harness²⁰ at the University of Michigan state that total thyroidectomy has been basic in the treatment of nearly all primary malignant lesions of the thyroid for the past 15 years in their hospitals. These authors report 4.8 per cent unilateral nerve injury and permanent hypoparathyroidism in 5.4 per cent. Although our series is small, we have had no permanent nerve injury or permanent hypoparathyroidism in our group of malignant cases. The approach advocated by Hardin and Hardy²¹ may have considerable merit in prevention of some of the tragic complications of total thyroidectomy. These authors have adopted a policy of total lobectomy on the involved side and radical subtotal lobectomy on the contralateral side of the

predominant mass. Our follow-up ranges from 25 years to 6 months with no deaths. There was one death in a clinic patient directly due to thyroid cancer. This patient, a 65-year-old black male, was not included in our series as he was operated on elsewhere and was first seen by us six years after his primary operation which was a subtotal thyroidectomy for a follicular adenocarcinoma. This patient presented with a large mass in his neck and multiple metastases throughout both lung fields. He was treated with cobalt to the neck, a therapeutic dose of I^{131} and whole thyroid extract. Death occurred two years after treatment was started and was due to widespread metastatic thyroid carcinoma.

Cady et al²² in a recent Lahey Clinic review of 792 patients with differentiated thyroid carcinoma concluded that lymph node metastasis was found to exert a protective effect in all categories of disease analyzed. This had been previously noted by other authors. Surgical treatment recommended by these authors is subtotal thyroidectomy for patients at high risks of death from disease as defined by combinations of age, sex and extraglandular extension. Patients at low risk or with small carcinomas are treated satisfactorily by lobectomy alone. No improvement could be demonstrated in their cases by the use of radiotherapy after surgery. Thyroid hormone administered postoperatively was of benefit in patients with papillary and mixed forms of carcinoma in all age groups but did not affect survival in patients with follicular carcinoma of the thyroid gland.

Summary

The authors present a study of 123 solitary nodules of the thyroid and 83 multinodular goiters. Of the solitary nodules, 8.9 per cent were malignant and 2.4 per cent of the multinodular goiters were malignant. The relationship of prior irradiation to cancer of the thyroid gland is pointed out. Although none of the authors' cases of carcinoma of the thyroid gland was subjected to prior irradiation of the neck during childhood, a careful history should be taken in all cases of nodular goiters regarding this

aspect of their past history. In view of the high incidence of complications as reported in the literature, total thyroidectomy probably should not be routinely done for carcinoma of the thyroid arising in a solitary nodule. A more conservative course as advocated by Cady et al²² or by Hardin and Hardy²¹ would certainly lead to less serious complications. Thyroid hormone was given routinely to postoperative patients by the authors in all cases of total thyroidectomy. In view of Cady's²² report, thyroid should probably be used in all papillary and mixed papillary and follicular carcinomas postoperatively. Cobalt therapy was used in one of our cases postoperatively and was of questionable value. The authors are of the opinion that all nodular goiters both solitary and multinodular should be subjected to surgery provided the patient's general condition permits. If malignancy is present, a near total thyroidectomy should be performed followed by thyroid hormone therapy. The use of radioactive iodine and cobalt postoperatively is not recommended. ★★★

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BERNARD S. PATRICK, M.D., and ROBERT A. SANFORD, M.D.

Jackson, Mississippi

IN DEALING WITH pain of malignant disease, neurectomy and rhizotomy have distinct, but limited usefulness. These nerve interrupting procedures lend themselves admirably well for lesions of the chest wall and abdominal wall, whereas they find little application for lesions involving the extremities or the brachial and sciatic plexus. Because of intermingling of the nerve fibers in the brachial and sciatic plexus, one must virtually totally denervate an extremity in order to be certain of complete elimination of pain. A neurectomy for this is impractical. A rhizotomy can be easily done, but leaves a limb almost equally useless as the loss of positional feedback to the spinal cord and cerebellum makes the muscular coordination of the affected extremity impossible. Thus for extremity pain problems, particularly those which arise from invasion of the nerve plexus, a cordotomy is generally superior. This will be discussed in a subsequent article.

For lesions about the face, sinuses, throat, and head, neurectomy and particularly rhizotomy are the primary means of long term pain control. The nerve supply to these regions does not lend itself well to tractotomy.

Except for the facial pain, techniques for neurectomy and rhizotomy have changed little in the past 30 years. Intercostal neurectomy whether surgical or chemical still remains most useful in control of pain of lateral and anterior chest wall malignant invasion. The fact that this peripheral neurectomy also paralyzes some intercostal musculature is usually of negligible consequence. Even a lysis of one or more of the lower thoracic nerves supplying abdominal musculature usually does not produce serious loss of function in the patient otherwise ill with malignancy. For pain arising from the costovertebral angle, however, it then becomes necessary to interrupt pain pathways within the spinal canal via rhizotomy in order to be sure of denervating the posterior division branches which supply this region.

From the Department of Neurosurgery, University of Mississippi Medical Center, Jackson, MS.

In the terminally ill patient, when pain relief is needed for a life expectancy of one to three months, pain from the anterior or lateral chest wall can often

This is the third of a series of articles dealing with pain associated with malignant neoplasms. The current article discusses neurectomy and rhizotomy and their usefulness for lesions of the chest wall and abdominal wall. The authors explain the surgical techniques and give indications for and complications of each.

be relieved simply by multiple chemical neurectomies accomplished with the use of absolute alcohol injected adjacent to the respective intercostal nerves (see Figure 1).

Technique

A skin wheal is raised with one per cent Xylocaine over the posterior angles of the rib segments. A 20 or 22 gauge 1½ inch needle is inserted to contact the rib and is carefully walked off the inferior edge of the rib and then advanced 0.5 cm. Aspiration is needed to determine that one is not in the lung. One-half cc. of one per cent Xylocaine is injected to lessen the pain of the alcohol to follow. After a delay of one to two minutes then 0.5 to 1.0 cc. of absolute alcohol is injected at each intercostal nerve level. On the following day the denervated area is tested and if any residual sensation is left, repeat injections may be done where needed. Usually one or two segments above and below the level of pain require denervation in order to provide satisfactory pain relief.

Pneumothorax can occur as a complication of this procedure, but in actual practice rarely does. This procedure can be done at bedside in a patient who is difficult to move.

Surgical intercostal neurectomies generally involve more trauma to the patient with greater risk of

pneumothorax than is usually justified in an otherwise terminally ill patient. Because, when neurectomy is indicated, generally multiple neurectomies are required to cover relatively broad areas.

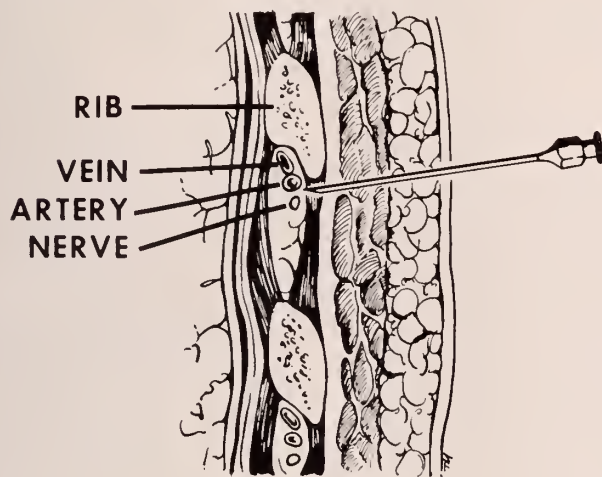


Figure 1

Spinal rhizotomy (interruption of the nerve root within the spinal canal) can easily be accomplished via surgical laminectomy. This procedure more completely denervates the thoracic wall and abdominal wall while at the same time interrupting pain arising from the costovertebral angle. The risks to the patient are not substantially greater than multiple intercostal neurectomies. However, the fact that the spinal canal must be opened, exposes the patient to risk of paralysis of the legs if complica-

tions such as hemorrhage or deep wound infection were to occur. These complications are, however, quite rare today. Surgical rhizotomy usually requires general anesthesia and is a major procedure. The results, however, are gratifying, for pain relief is usually permanent in the region denervated.

In terminally ill patients of short life expectancy, spinal rhizotomy can be accomplished by the use of absolute alcohol injected into the spinal fluid in the subarachnoid space (see Figure 2). This procedure requires considerable skill and is not for the occasional practitioner. It can be done at bedside or in the treatment room. When technically successful this procedure usually results in relief of pain in the affected region for periods up to two to three months. This procedure in our hands has been particularly useful in the terminally ill patient whose condition does not permit a surgical procedure of any severity. This type of chemical rhizotomy is often useful for extremity pain as well as trunk pain. There generally is some muscular weakness that occurs with this rhizotomy, but this usually is a small inconvenience in comparison to the relief of pain. For those interested, additional details regarding this technique can be found in "Management of Pain" by Bonica.¹

In the control of facial pain by rhizotomy, a very noteworthy advance has taken place in the past 8 to 10 years. From work developed by Sweet, techniques have evolved whereby rhizotomy of the trigeminal nerve (cranial nerve V) can now be accomplished by direct needle puncture via the foramen ovale followed by the application of a radio frequency current to this needle creating a controllable thermal lesion in the nerve root (see Figure 3). Classically this nerve root has been interrupted surgically via craniotomy. Many other techniques have been tried and been found wanting. Injection of absolute alcohol has been used intermittently for 55 years, but has considerable risk of paralyzing the VIth, VIIth, and VIIIth nerves as well. The injection of phenol into the ganglion or nerve root carries somewhat less, but similar risks. The injection of boiling water was used by a few some 25 years ago, but with limited success. The ordinary "Bovie" cautery apparatus cannot be used in the nervous system because lesions created by this apparatus are extensively damaging and uncontrollable. The use of a radio frequency current, however, can produce a discreet controllable lesion that does not extend beyond a few millimeters from the tip of the needle. The procedure of radio frequency thermocoagulation of the root of the trigeminal nerve can be accomplished in patients who otherwise could



Figure 2

NEURECTOMY / Patrick and Sanford

not tolerate a major procedure such as craniotomy. The results in our hands as well as those reported throughout the country indicate that this procedure is almost totally replacing the classical rhizotomy via craniotomy of the past 50 years. It is often singularly useful in the patient with malignant involvement of the face, sinuses, etc., when the extent of disease makes a surgical procedure through an invaded and often infected region unduly hazardous.

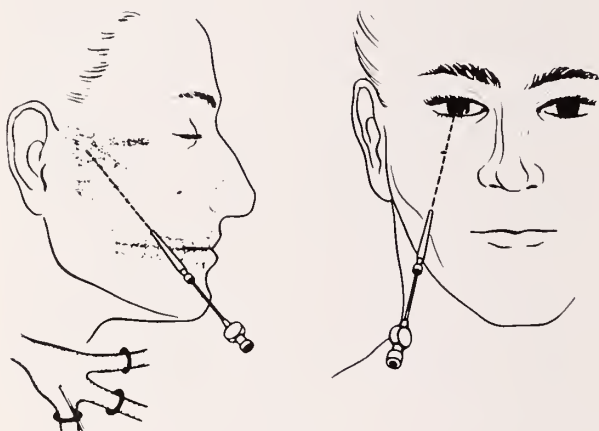


Figure 3

Often seen are cases of malignant invasion of the face and throat in which more extensive denervation of this region is required than can be accomplished with trigeminal rhizotomy. In these circumstances it then becomes necessary to perform multiple rhizotomies via suboccipital craniotomy which permits access to the roots of the trigeminal nerve, the glossopharyngeal nerve, and the vagus nerve. These all

can be lysed through a single craniotomy opening and by slightly enlarging the operative exposure, one can, where necessary, lyse the sensory divisions of the 1st, 2nd, and 3rd spinal nerves in the upper neck as well. Such a procedure can produce anesthesia over the entire half of the face, head, and upper neck (see Figure 4).

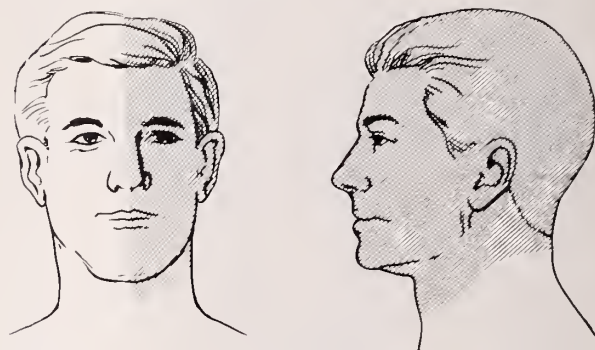


Figure 4

Operative procedures such as this, considered unduly hazardous in years past have, as a result of improved techniques and equipment such as the operating microscope, brought to many otherwise tortured patients, a grateful measure of relief. ★★★

(The next article will deal with cordotomy and new percutaneous techniques.)

2500 North State Street (39216)

References

1. Bonica, John J.: Management of Pain. 498-509. Lea and Febiger, 1953.
2. Sweet, W. H. and Wepsic, J. G.: Controlled Thermo-coagulation of Trigeminal Ganglion and Rootlets for Differential Destruction of Pain Fibers. Part I: Trigeminal Neuralgia. J. Neurosurgery 40:143-156, February 1974.

I, do, therefore, invite my fellow citizens in every part of the United States . . . those at sea . . . those sojourning in foreign lands to observe . . . a day of thanksgiving and praise to our beneficent Father Who dwelleth in the heavens. . . .

ABRAHAM LINCOLN

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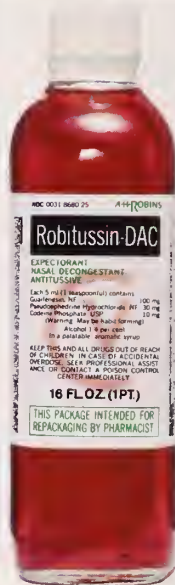
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Reduces severity, frequency of attacks.
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Therapeutic Index, Jan., Dec., 1976. IMS America
of Drugs, A.M.A. Drug Evaluations, 2nd ed.

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Pseudoephedrine HCl, NF **30 mg.**

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Relieves congestion, reduces edema, promotes drainage.
60 mg pseudoephedrine in a 2-teaspoonful adult dose.

Available in pints only. You prescribe the quantity dispensed

References: *Handbook of Disease & Therapeutic Index*, Jan.-Dec., 1976, IMS America Ltd., Ambler, Pa. 1
Pharm. Assn., Dept. of Drugs, A.M.A. Drug Evaluations, 2nd Edition, Publishing S

NF 100 mg. Pseudoephedrine Hydrochloride
syrup. Alcohol, 1.4 per cent. INDICAT
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 *National Disease & Therapeutic
 †Amer. Med. Assn., Dept. of Drug
 Acton, Mass., 1973, pp. 482-3.

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National Disease & Therap.
† Amer. Med. Assn., Dept. of
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**Pseudoephedrine Hydrochloride, NF 30 mg; Codeine
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CONTRAINDICATIONS For the temporary relief of nasal congestion caused by upper respiratory tract inflammation or allergic rhinitis. Hypertensive disease, recent myocardial infarction, glaucoma, prostatic hypertrophy, severe hypertension, and known hypersensitivity to pseudoephedrine hydrochloride or codeine phosphate are contraindications to the use of this product. The use of this product is also contraindicated in patients taking MAO inhibitors or other drugs which may interact with it. Patients who have been treated with sulfa drugs should avoid this product because of the possibility of cross-sensitivity reactions.

WARNINGS: This product contains pseudoephedrine hydrochloride, a sympathomimetic amine. It should be used with caution in patients with cardiovascular disease, diabetes mellitus, hyperthyroidism, and in those receiving digitalis glycosides. Prolonged use of this product may result in rebound congestion. If symptoms persist after 7 days of treatment, consult your physician. Do not take more than the recommended dose. Do not use if you are taking MAO inhibitors or other drugs which may interact with it. Patients who have been treated with sulfa drugs should avoid this product because of the possibility of cross-sensitivity reactions.

DOSAGE AND ADMINISTRATION: Adults: Two capsules three times daily after meals. Children: See package insert for full prescribing information.

ADVERSE REACTIONS: Dry mouth, drowsiness, headache, insomnia, constipation, urinary retention, and increased intraocular pressure have been reported. These effects are usually mild and transient. If they occur, discontinue use and consult your physician.

PHARMACOLOGY: Pseudoephedrine hydrochloride is a sympathomimetic amine which acts as a decongestant by stimulating the release of norepinephrine from sympathetic nerve endings. Codeine phosphate is an opioid analgesic which acts centrally to relieve pain and suppress cough reflexes.

CLINICAL STUDIES: In clinical studies, this combination product was found to be effective in relieving nasal congestion and providing analgesia and cough suppression in patients with upper respiratory tract infections.

HOW SUPPLIED: Each bottle contains 60 capsules. Each capsule contains 30 mg pseudoephedrine hydrochloride and 15 mg codeine phosphate.

STORAGE: Store at controlled room temperature (20°-25°C). Protect from moisture and light.

CAUTION: Keep this and all medications out of the reach of children. This product contains codeine, a habit-forming drug. Do not take more than the recommended dose. Do not use if you are taking MAO inhibitors or other drugs which may interact with it. Patients who have been treated with sulfa drugs should avoid this product because of the possibility of cross-sensitivity reactions.

REFERENCES: 1. American Medical Association. "Drug Facts and Comparisons." Vol. 1. H.W. Saunders Co., Philadelphia, PA, 1980. 2. FDA Center for Drug Evaluation and Research. "FDA Approved New Drugs." Vol. 1. U.S. Government Printing Office, Washington, DC, 1980.

OTHER INFORMATION: This product is not intended for use in children under 12 years of age. Consult your physician for further information.

DATE OF PREPARATION: October 1980

REVISIONS: None

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Radiologic Seminar CLXXV: Gray-Scale Ultrasonography of Renal "Cystic" Lesions

SANDRA A. RHODEN, M.D., and JOHN Y. GIBSON, M.D.

Jackson, Mississippi

ALTHOUGH MOST echo-free masses of the kidney are simple cysts, not all lesions of the kidney that meet the ultrasonic criteria of the common benign simple cyst are common benign simple cysts¹ (see Figure 1).

The three basic criteria of a simple cyst require that (1) it is echo-free, (2) it has smooth, well defined margins, and (3) there is an increase in sound reflections from the far wall compared to those reflections at a similar depth through normal tissue adjacent to the cystic mass.² Additional lesions that have been known to meet these requirements are hydronephrosis, polycystic kidney, abscess, hemorrhagic cyst, hematoma, multicystic kidney, neoplasm with cystic degeneration, cyst with neoplasm in its wall, renal artery aneurysm, calyceal diverticulum and caliectasis.^{1, 3} Their appearance may suggest the sonolucent "light bulb sign" of fluid collections⁴ (see Figure 2). On gray-scale ultrasonic scans the light bulb refers to the white echo-free region of a fluid collection adjacent to normal renal parenchymal echoes which serve as an indicator of proper technique. Some of the above lesions contain multiple "light bulbs."

Second only to the simple renal cyst, hydronephrosis is the next most common echo-free renal mass.¹ This "cystic" lesion of the kidney actually has a spectrum of ultrasonic patterns. Early hydronephrosis is recognized by separation of the normal central cluster of echoes on the transverse scan, forming a ring or open ring "C" shaped echo pattern with a sonolucent center.⁵

On longitudinal sections there is separation of the linear central echoes forming an oblong ring with an echo free center. With increasing severity the kidney appears cystic with multiple septa radiating from the center of the pelvic region (see Figure 3). The cysts are actually dilated pelvis and calyces. Severe forms of hydronephrosis may appear as a cystic sac,

mimicking a large simple or lobulated cyst. A special case of hydronephrosis is uretero-pelvic junction obstruction in which the dilated extrarenal pelvis and dilated calyceal systems appear as a dumbbell shaped sonolucent area.³

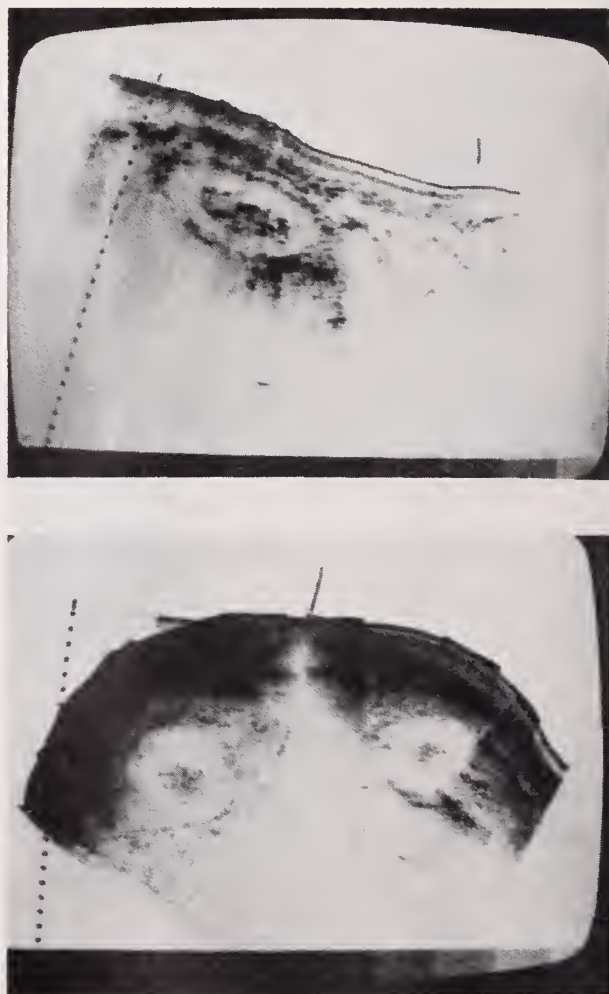


Figure 1. Utilizing a 2.25 MHz transducer, the prone position, and no bowel prep, these normal renal scans were obtained. Note homogenous low intensity echo pattern of renal parenchyma and dense central echo pattern representing renal hilar structures and pelvicalyceal systems.

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From the Department of Radiology, University of Mississippi Medical Center, Jackson, MS.

Incidence of false positive ultrasound diagnosis of hydronephrosis has been described as 0-10 per cent, but false negatives rarely occur. Therefore, a study negative for hydronephrosis virtually excludes it, but a diagnosis of hydronephrosis by ultrasound requires confirmation via retrograde or antegrade pyelogram in the absence of a diagnostic urogram.⁶

Renal sinus lipomatosis might be mistaken for early hydronephrosis, for it, too, separates the central clump of pelvicalyceal echoes and can give a ring configuration on transverse sections. However, distinction should be clear if one remembers that in lipomatosis there are weak central echoes and there is attenuation of sound through the region, whereas, in hydronephrosis at proper settings no central echoes are elicited and there is an increase of sound energy beyond the dilated collecting system rather than attenuation.⁷

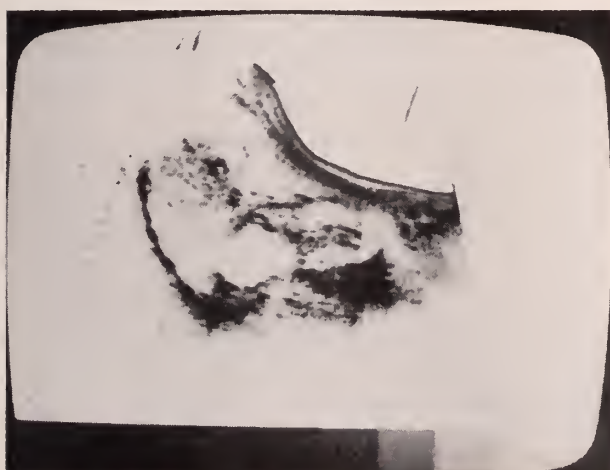


Figure 2. Basic criteria of a benign simple cyst are met by this upper pole renal lesion. The "light bulb sign" is also present, evidenced by the white cystic area in contrast to normal renal parenchymal echo pattern (supine, longitudinal scan).

Evaluation of renal failure patients or those with a nonvisualizing kidney confronts the ultrasonographer not infrequently with trying to distinguish between "cystic" lesions of the kidney such as hydronephrosis and polycystic kidneys or merely to exclude hydronephrosis. The urogram, which often contributes valuable information toward the determination of which one of these entities is present, occasionally is inadequate or delays diagnosis and treatment.⁸ For example, even in a neonate with normal kidneys renal function may not allow adequate urographic renal visualization for several days and a diagnosis may be reached earlier or solely by ultrasound. Furthermore, being able to visualize renal size and establish that a kidney is small may

not be an adequate urogram as even a contracted kidney can become obstructed.⁸ When there is a case of obstruction, diagnosis and management could be delayed while awaiting 24 to 48 hour urogram films to determine if "cystic" lesions fill with contrast, thereby distinguishing between dilated pelvicalyces and other cystic spaces as in polycystic disease, multicystic kidneys, and multiple renal cysts.



Figure 3. These transverse and longitudinal prone scans demonstrate severely hydronephrotic kidneys. Multiple cystic structures and absence of normal dense central pattern are noted.

Ultrasonically, severe polycystic disease is somewhat similar to hydronephrosis, but polycystic kidneys have a diagnostic pattern consisting of a random distribution and ragged outlines of cysts, differing from the cystic areas of hydronephrosis that tend to radiate from the center of the kidney⁵ (see Figure 4).

Gray-scale nephrosonography, focused transducers and appropriate signal processing have led to resolution of 2-3 mm. as opposed to about 2 cm. on

bistable systems.⁹ As a result, modern equipment provides resolution of cystic lesions of the kidney of several mm. size and permits early detection of polycystic kidneys that may not be detectable even with high-dose urography.¹⁰ Polycystic kidney disease of the adult type (Potter Type III) is a genetic disorder transmitted in autosomal dominant fashion with variable expression, but there is virtually 100 per cent penetrance if the patient survives to the eighth or ninth decade. Clinical presentation occurs commonly during middle age, but early detection in childhood allows genetic counseling to children of known polycystic parents.¹¹ Early detection also improves long term prognosis by allowing early referral to a transplantation center.¹²

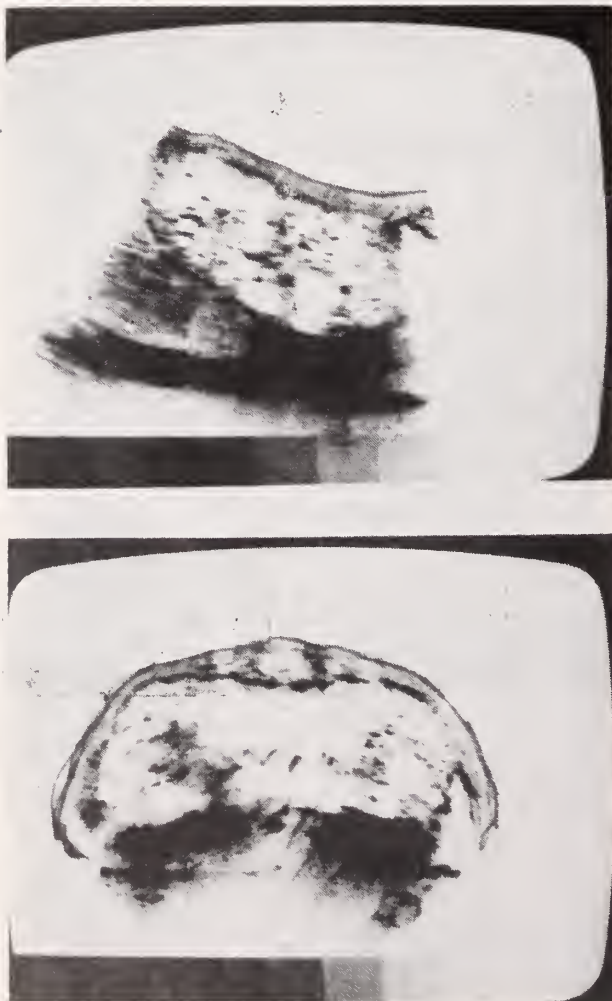


Figure 4. Multiple randomly distributed cystic areas of varying size are present in these polycystic kidneys which are characteristically grossly enlarged. There persists a dense central echo pattern bilaterally on transverse section (patient prone).

Another common echo-free renal mass that occurs with less frequency than the simple renal cyst or hydronephrosis is the renal carbuncle. Although it can meet the criteria of a simple cyst, it may have irregular walls and contain echoes from debris. An unusual shape may be present in some sections.¹

Remaining cystic entities are distinctly less common and sonogram should be used with direct reference to urogram and clinical information. Sonography of renal cystic lesions is a complementary study. The sonogram itself may dictate whether arteriography, radio-nuclide studies, retrograde or antegrade pyelograms, or cyst puncture are to follow in the work-ups of the lesion.¹

While the use of the ultrasound scan information alone in evaluation of the urinary tract provides a diagnostic accuracy of 80 per cent, the additional use of clinical information and highdose urography increases the accuracy to better than 95 per cent.¹³ There are reports of 75-95 per cent accuracy in separating cystic and solid lesions ultrasonically.¹ Furthermore, the false negative rate, i.e., misdiagnosing a tumor as a cyst, is low, being in the 2-3 per cent range for masses greater than two centimeters in size.² There are occasional circumstances that do allow this diagnostic tool to be used in a primary or screening fashion without the urogram such as when radiation exposure is unwarranted as in pregnancy or in frequent followup studies, when there is an allergy to contrast media or when poor renal function precludes adequate urogram.² Ultrasound screening of children of known polycystic parents appears promising.

Summary

The gray-scale ultrasonic criteria of renal cysts have been used to relate a number of renal lesions in order to present a current assessment of the usefulness of ultrasound as a complementary study in their diagnosis. Ultrasonic patterns of several cystic entities including hydronephrosis and polycystic kidneys have been presented to aid in differentiating these entities, as ultrasound may occasionally prove to be the sole mode of diagnosis. ★★★

2500 North State Street (39216)

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For a complete list of the (13) references, write to the authors.

POSTGRADUATE CALENDAR

Dec. 2, 1977

WHEN THE PARISHIONER IS THE PATIENT: ISSUES FOR CLERGY AND PSYCHOTHERAPISTS
University Medical Center, Jackson

Sponsored by the University Hospital, the University of Mississippi School of Medicine Department of Psychiatry, and the University of Mississippi Medical Center Division of Continuing Health Professional Education.

Coordinator: James L. Travis, Ph.D., Chaplain, University Hospital.

This workshop is designed to clarify and facilitate ways in which clergy and psychotherapists may work together more effectively. Guest faculty are Charles E. Myers, Th.D., pastor, Alta Woods Baptist Church, Jackson; Wayne E. Oates, Th.D., professor of behavioral sciences and psychiatry and pastoral counselling, the University of Louisville School of Medicine, Louisville, KY; and John J. Schwab, M.D., chairman, Department of Psychiatry, University of Louisville School of Medicine, Louisville, KY. Fee: \$10.00. Credit: 6 contact hours, .6 CEU, Category 1, AMA.

Dec. 3, 1977

COMMON HAND INJURIES
Mississippi Methodist Rehabilitation Center, Jackson

Sponsored by the Mississippi Methodist Rehabilitation Center, the University of Mississippi

School of Medicine Department of Surgery, and the University of Mississippi Medical Center Division of Continuing Health Professional Education.

Coordinators: Charles W. Emerson, Jr., M.D., chief, Hand and Upper Extremity Service, Mississippi Methodist Rehabilitation Center; and Michael E. Jabaley, M.D., professor of surgery and chief of the division of plastic surgery, University of Mississippi School of Medicine.

This one-day seminar is designed primarily for family practitioners and emergency room physicians. The program will include discussions on hand infections; treatment of PIP joint injuries; proper hand immobilization; evaluation of primary care of the burned hand; and management of wrist fractures. Fee: None. Credit: 4 contact hours, .4 CEU, Category 1, AMA.

FUTURE CALENDAR

Jan. 9-13, 1978

EKG INTENSIVE COURSE
University Medical Center, Jackson

Jan. 11, 1978

HYPERTENSION SEMINAR
University Medical Center, Jackson

Mar. 9-11, 1978

SURGICAL FORUM V
Holiday Inn Downtown, Jackson

Mar. 30-April 1, 1978

GASTROENTEROLOGY UPDATE
Ramada Inn Coliseum, Jackson

May 1-4, 1978

MISSISSIPPI STATE MEDICAL ASSOCIATION
Ramada Inn Coliseum, Jackson



The President Speaking

Immunization Campaign Begins

JAMES O. GILMORE, M.D.
Oxford, Mississippi

NEW GRAFFITI have begun appearing on the pavements of grammar school playgrounds in Mississippi and across the country. It's a bit different from the usual, however, because these are hopscotch courts which are intended to alert children to the need for immunization. The spaces on the hopscotch layout are labeled with the names of the controllable diseases—measles, rubella, polio, tetanus, diphtheria, whooping cough—and in place of "Sky Blue," "Immunization" has been substituted.

The project is being sponsored by the AMA Auxiliary and its state chapters and it is designed to alert young parents, through their children, to the need for immunization. It is estimated that some 40 per cent of all American children under 15 are not properly immunized. This is probably due in large part to the fact that most young parents grew up free of the fear of epidemics of polio and of other childhood diseases.

The hopscotch project is part of an AMA-sponsored MSMA-supported public service TV campaign which uses as a theme children playing hopscotch. "Controllable disease characters" are introduced at an "AMA Immunization Bowl" where they have gathered to play a game of hopscotch.

Mrs. Chester Young, president of the auxiliary, points out that "we could see another polio epidemic unless the level of immunization is raised. And to someone who remembers the dread of polio, that's appalling."

★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XVIII, NUMBER 11

NOVEMBER 1977

Thoughts on Government and the Future

For those who feel we are going to the dogs and our society is doomed, there may be a brighter day ahead. The social evils that exist, the deficit spending and rampant inflation that seem to continue and worsen, the ill preparedness of the country for war, the moral decay that seems apparent all around us are all brought to mind each day by the media at all levels. It is not easy to keep an optimistic view.

A world that appeared so infinite two generations ago now has shrunk and we can see the end of fossil fuels and the limits of space available for agriculture. Perhaps alternative energy sources will be discovered but certainly none are proven to date.

Our government is slowly destroying initiative by increasing the dependency of such a large segment of our society. It is acting fiscally irresponsibly by ever increasing deficit spending. Social Security, our public insurance program, is virtually without funds and must depend on increases in rates and higher taxes to defray payments.

A new magazine is being published—"Quest." It is geared to those who have hope and want to see a brighter side of our picture and none of the myopic view presented by the media.

Let us all be reminded that honor, integrity and morality are not dead. Let us recall that never before in history has a society enjoyed food, shelter, creature comforts and medical care to the extent that exists in these United States today. Some part of this is due to the government we so easily condemn.

Perhaps we and those less fortunate can continue to enjoy this "good life" with cooperation and wise and slow change in the direction of government.

Dr. Arthur Sackler, publisher of *Medical Tribune*, has labeled himself a conservative liberal with radi-

cal tendencies. This description caught my eye as it seems so like my own.

What a wonderful thing it would be for all if this nation could continue to provide this level of care for all its citizens without bankruptcy.

Even the most callous person could hardly begrudge his less fortunate neighbor food, shelter, and medical care. We in the medical profession can take an objective look at our situation and consider what we can do as our part and not blindly fight every issue solely because it is government sponsored. If we don't face up to our responsibility, we can only expect further government intervention.

Remember the welfare state that is so often looked down on would never have arisen had we followed the Christian ethic to which most of us subscribe.

The most constructive change that I believe could be made would be to limit senators and congressmen to one term with retirement benefits sufficient to attract our most qualified people. Think on this.

W. MONCURE DABNEY, M.D.

Editor

Crystal Springs, MS

Medico-Legal Brief

N.Y. Court Upholds Medical Society's Right to Discipline Its Members

In a case involving a Peer Review Committee's review of a physician's bill, a New York trial court refused to grant the physician injunctive and declaratory relief because the physician had not exhausted his administrative remedies.

The physician had treated a patient who was injured in an automobile accident. The physician's bill was for \$11,000. After the patient submitted the bill to his insurer, the insurer complained to the county

medical society that the fee was excessive.

The medical society's Peer Review Committee notified the physician of its intended review of the complaint, and requested him to appear before the committee.

The physician chose not to appear and the committee held the review without him. Following the review, the committee sent the physician a letter telling him that the committee had decided that his total bill for professional services was "excessive" and documenting the reasons for its decision. In the letter the committee also suggested that the physician "restructure" his bill in keeping with their standards.

The physician then sent the committee a letter agreeing to reduce his bill "under protest" and agreeing to meet with the committee to discuss the complaint.

Before the scheduled rehearing, however, the physician commenced a legal proceeding against the medical society. He obtained an order to show cause and a temporary restraining order preventing the Peer Review Committee from conducting the scheduled rehearing.

The physician then asked the court for a preliminary injunction, and the court denied it.

The physician was bound by the medical society's bylaws, particularly those dealing with discipline, the court said.

Under the New York Not-For-Profit Corporation Law, the county medical society, a not-for-profit corporation, has the power to conduct investigatory and advisory hearings to determine whether a particular fee is obviously excessive and detrimental as to standard of care rendered, the court noted.

Under the medical society's bylaws, the Peer Review Committee was established to investigate physicians' fees. Also under these bylaws, a medical society member is bound by any determination as to excessiveness of a fee. Failure of a member to abide by the determination constitutes a basis for referral to the Board of Censors of the medical society for possible disciplinary action, the court noted.

The court said that the physician's motion for a preliminary injunction conflicted with the authority given to the medical society under the Not-For-Profit Corporation Law. The court also said that injunctive relief was premature because the physician had not exhausted the remedies afforded to him pursuant to the medical society's bylaws and the Not-For-Profit Corporation Law.

The physician failed to establish a clear showing of irreparable damages, of primary concern in de-

termining a party's right to a preliminary injunction, the court said.

Since the medical society's procedure was in its initial stage, the potentiality of possible censure, suspension or expulsion from the medical society did not constitute irreparable injury, the court added.

The court also denied the physician a permanent injunction and a temporary injunction on the basis that the same principles applied.

In addition, the court did not agree with the physician's claim that peer review would violate his due process rights. The deprivation of such interest must be by some direct state action and that means the state's involvement must be significant, the court noted.

"While the state, through its legislature, has recognized that a medical society may promulgate its own rules and regulations concerning discipline of its members, it has no involvement with the disciplinary procedures guarding members and its involvement, if any, and in no way aids or indicates approval of any complained activity of a member physician," the court said.

The court found that the medical society's bylaws clearly afforded any member subject to review or disciplinary action more than minimal safeguards of due process. "In effect, the bylaws herein meet due process standards even to the level required were the state, in fact, involved," the court said.

The physician made no showing of any extraordinary circumstances that required the court to intervene on his behalf and abort the medical society's attempts to resolve matters in an orderly and expeditious fashion under the procedures provided, the court said.

Accordingly, the court denied the physician's motion in its entirety, vacated the temporary restraining order, and dismissed the physician's complaint without prejudice.—*Ettenson v. Dutchess County Medical Society, Inc.*, Docket No. 1977/95 (N.Y. Sup. Ct., June 15, 1977)

DEATHS

ACREE, FRANK M., Greenville. Born Dover, TN, Aug. 13, 1897; M.D., University of Tennessee College of Medicine, Memphis, 1923; interned Baptist Hospital, Memphis, Sept. 1921-June 1923; medicine residency, Birmingham Baptist Hospital, Birmingham, AL, Nov. 1923-Sept. 1924; died Sept. 5, 1977, age 80.

MELVIN, JOSEPH P., JR., Jackson. Born Shaw, MS, Sept. 17, 1918; M.D., Tulane University School of Medicine, New Orleans, LA, 1943; interned Touro Infirmary, New Orleans, 1943-44; medicine residency, Tulane, New Orleans, 1944-46; Emeritus member of MSMA and AMA; died April 16, 1977, age 58.

METCALF, ORRICK, JR., Natchez. Born Natchez, MS, July 12, 1928; M.D., Temple University School of Medicine, Philadelphia, PA, 1953; interned Charity Hospital, New Orleans, LA, one year; general surgery residency, same, 1954-56 and 1958-60; surgery residency, F. Lahey Clinic, Boston, MA, Sept. 1960-Aug. 1961; thoracic surgery residency, Los Angeles, CA, 1963-64; died Sept. 19, 1977, age 49.

NEW MEMBERS

BALL, LEONARD, Gulfport. Born Gulfport, MS, Feb. 21, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned Wilford Hall USAF Hospital, San Antonio, TX, one year; psychiatry residency, Tulane University, New Orleans, LA, 1971-75; elected by Coast Counties Medical Society.

DUGGAR, DAVID L., Ocean Springs. Born Jackson, TN, Dec. 26, 1944; M.D., University of Tennessee College of Medicine, Memphis, 1968; interned City of Memphis Hospitals, Memphis, one year; pediatrics residency, same, 1970-71; pediatric residency, Keesler USAF Hospital, Biloxi, MS 1973-74; elected by Singing River Medical Society.

LANDSEN, FRANK T., Biloxi. Born Eustis, FL, April 23, 1928; M.D., Ohio State University College of Medicine, Columbus, 1956; interned St. Rita's Hospital, Lima, OH, one year; general surgery residency, Akron City Hospital, Akron, OH, 1957-61; thoracic surgery residency, Case Western Reserve, 1963-65; plastic surgery residency, Tulane University, New Orleans, LA, 1975-77; elected by Coast Counties Medical Society.

HOFFMAN, EDWARD S., Pascagoula. Born Rochester, NY, May 31, 1939; M.D., University of Maryland School of Medicine, Baltimore, 1965; interned S. Baltimore General Hospital, Baltimore, one year; ob-gyn residency, Charity Hospital, New Orleans, LA, 1969-72; elected by Singing River Medical Society.

SMITH, BENNETT E., Hattiesburg. Born Oxford, MS, Aug. 2, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned UMC, Jackson, one year; pediatric residency, same, one year; residency in adolescent medicine, University of Colorado, Denver, 1974-75; elected by South Mississippi Medical Society.

PERSONALS

WAYNE BYRD announces his association with Drs. Watkins, Allen and Byrd of The Medical Group for the practice of family medicine in Quitman at 305 Archusa Avenue. Dr. Byrd and his family were honored with a welcoming reception given by the H. C. Watkins Memorial Hospital on Sept. 11.

THOMAS H. CABELL announces the opening of his office for the family practice of medicine at Suite 220, St. Dominic Medical Offices, 971 Lakeland Drive, in Jackson.

JOSEPH J. CHAPPELL, JR., announces the opening of his office for the practice of ophthalmology at Tupelo Eye Center, 610 Brunson Drive in Tupelo.

CLAYTON S. COOK of Hattiesburg announces the location of his office at 713 Arledge Street for the practice of general surgery.

THOMAS D. CROWSON has associated with Internal Medicine Associates, P.A. of Meridian for the practice of gastroenterology and internal medicine at 1301 20th Avenue.

JERRY M. CUNNINGHAM announces the opening of his office for the practice of internal medicine at 344 Arnold Avenue, North Wing, in Greenville.

BEN P. FOLK, JR., of Jackson announces the removal of his office to Suite 217, Medical Arts Building, 1151 N. State Street, for the practice of internal medicine.

HENRY HILLMAN announces the opening of his office for family practice at 127 Lameuse Street, Suite 105, in Biloxi.

LLOYD M. HOFER has associated with G. T. Kimbrough and F. E. Dement, III, in the practice of pediatrics at 207 South 28th Avenue in Hattiesburg.

NOEL WOMACK of Jackson has been elected chairman of the board of directors of United Way's Jackson Speech and Hearing Clinic.

THE LITERATURE

Book Review

Psychosomatic Aspects of Allergy. By Claude A. Frazier, M.D. 257 pages. New York: Van Nostrand Reinhold Company, 1977. \$14.95.

Psychosomatic Aspects of Allergy by Claude A. Frazier is quite good, is very comprehensive and adheres pretty well to the subject. It is interesting to note the numbers of "symptoms" discussed, which ordinarily would not be diagnosed as "allergy," but which apparently should be considered to occur as the result of allergy. Many of these conditions such as some headaches, mood disturbances, numbness, periods of disorganization or disorientations and others *can be* the result of allergies particularly to foods. In other words, treatment of a definite allergy—such as asthma—has often relieved or diminished a "hidden" allergic symptom. Surely, all allergists have observed this occurrence.

The book would perhaps not be of more than passing interest to the average man in medicine. However, to the physician limited to the treatment of allergic diseases, it would be very interesting. Allergists could not help observing that some of his conclusions are definite. It is, however, very questionable as to whether the nervous or psychosomatic factor could ever produce the real allergic symptoms—such as hay fever—except in a definitely allergic individual.

It is questionable as to whether the psychosomatic influence in allergy is any greater than any other chronic disease.

He seems to have found more definite allergic symptoms to foods than most allergists. Much work needs to be done on food allergy.

I would recommend the book to all who confine their work to treating allergic diseases.

GEORGE W. OWEN, M.D.
Jackson, MS

LETTERS

SIRS: During the past several months, I have heard on two occasions public comment regarding an arti-

cle in the October '76 issue of *Contemporary OB-GYN*. This article related among other things the drop in maternal and infant mortality which has been seen in the United States over the past several decades. Public comments made by two prominent members of the medical association point out the fact that the District of Columbia which has the highest mortality rate also has the largest number of physicians per population. This information has been presented so as to imply that the unavailability of health care to the masses within our state is not the primary reason for our high infant mortality rate. While these figures do indicate a smaller physician patient ratio for the District of Columbia, there is no information regarding the distribution of these physicians and their availability to the indigent and low socioeconomic groups within that area. In fact, a large number of these physicians are located at centers such as the Walter Reed Hospital and/or working in administrative positions within governmental agencies.

I feel it is erroneous to imply that this is evidence that even with sufficient care we would not see a further drop in the infant mortality statistics. I have seen, while working with the Board of Health, on numerous occasions individuals who had been unable to receive obstetrical or pediatric care either because of lack of physician manpower or refusal on the part of physicians to accept these patients. It is my feeling that we should work together to (1) provide more emphasis within the medical schools on finding mechanisms to provide care to those in our state who do not have it available, either because of financial or geographic constraints; (2) continue to encourage the State Medicaid Commission to raise Medicaid rates for physicians providing obstetrical and pediatric care and (3) encourage development of extended role nurses who can work through public agencies and with private physicians to provide care in shortage areas and to persons with limited financial means.

This is not to say that our environmental and sanitation problems do not enter into the mortality statistics—we all know they do; however, I feel that we should work diligently toward a pluralistic approach providing health care to those in our state who are presently not receiving it.

CLAUDE EARL FOX, M.D., M.P.H.
District Medical Director
State Board of Health
Tupelo, MS

MEDICAL ORGANIZATION

Dr. Lee Reid Receives the MPHA Felix Underwood Award

Dr. Lee R. Reid of Jackson has been awarded the Felix J. Underwood Award for his contributions and achievements during his career in public health.

The award which is the most coveted one given by the Mississippi Public Health Association was presented by State Health Officer, Alton B. Cobb, during the opening session of the MPHA's 40th annual meeting in Jackson.

During his years with the State Board of Health, Dr. Reid was affectionately known as the beloved teacher and counselor of the public health nurses.

He retired last May after providing 32 years of service to Mississippians stricken with tuberculosis and other chest diseases. He is now working part-time as a consultant with the State Board of Health's tuberculosis program.

Dr. Reid, who was born in Helena, AR, attended Millsaps College and received his medical degree from the University of Pennsylvania. He returned to Mississippi in 1945 to serve as chief surgeon at the Mississippi State Sanatorium until 1952. He then began full-time private practice in Jackson in diseases of the chest and thoracic surgery.

In 1952, Dr. Reid joined the State Board of Health's Tuberculosis Control Unit on a part-time basis as a consultant on diseases of the chest. After giving up his practice in 1965, he became a full-time consultant for Tuberculosis Control.

He interpreted chest x-rays for county health departments and made periodic visits to them to discuss problem cases. He also traveled to seven regional hospitals in the state to hold conferences on patients with chest diseases.

UMC Names Family Medicine Clinical Instructors

Ninety-five Mississippi physicians from 62 towns and cities have been named clinical instructors in family medicine for the University of Mississippi School of Medicine.

They'll help teach medical students about family practice through the Department of Family Medicine's preceptor programs.

Dr. Norman C. Nelson, UMC vice chancellor and

School of Medicine dean, announced the appointments following approval of the Board of Trustees, Institutions of Higher Learning.

All of the clinical instructors will have medical students working with them at some time during the school year. UMC juniors are required to do a three-week rotation with a local physician. Seniors may elect to do an additional four-week preceptorship to expand their knowledge and skills in family medicine.

The new clinical instructors already have served as preceptors for one year and have fulfilled other qualifications for the appointment. They attend UMC preceptor workshops, accept at least one student as a member of their health care team, and complete a minimum of 50 hours of continuing medical education each year.

The 1977-1978 clinical instructors include Drs. John M. Alford, Jr., Greenwood; S. D. Austin, Cleveland; Terald O. Bailey, Canton; J. Phil Balaski, Laurel; Jim C. Barnett, Jr., Brookhaven; Malcom D. Baxter, Hernando; Tom E. Benefield, Jr., Gulfport; Edgar Bobo, Pearl; Austin P. Boggan, Decatur; Leonard H. Brandon, Jr., Starkville; Lawrence H. Brisco, Tupelo; Lloyd Z. Broadus, Purvis; Ralph L. Brock, McComb; James E. Calloway, Jr., Louisville; Sidney A. Chevis, Bay St. Louis; Webster Cleveland, Jr., Booneville; David L. Clippinger, Gulfport; Robert E. Coghlan, Aberdeen; Edwin H. Cole, Richton; and Millard S. Costilow, North Carrollton.

Others are Drs. Samuel Creekmore, III, New Albany; Gene E. Crick, Minter City; Kenneth I. Cronin, Jackson; Thomas M. Davis, Jackson; Michael R. Foose, Yazoo City; Richard Furr, Ocean Springs; Elmo Gabbert, Meadville; Richard L. George, Columbus; James R. Griffin, Louisville; William M. Gillespie, Jr., Meridian; James O. Gilmore, Oxford; Thomas S. Glasgow, Grenada; James C. Graham, Enterprise; George W. Green, Jr., Scott; Walter D. Gunn, Quitman; John R. Harper, Taylorsville; John P. Hey, III, Greenwood; J. Edward Hill, Hollandale; Joe Hillman, Brookhaven; and Jerome B. Hirsch, Greenville.

Also Drs. Robert L. Holley, Oxford; R. T. Holingsworth, Shelby; Leroy Howell, Starkville; Charles Humphreys, Fayette; W. B. Hunt, Grenada;

ORGANIZATION / Continued

Robert N. Hurt, Indianola; Jerry W. Iles, Natchez; Edgar D. Johnson, Jr., Hattiesburg; Ben E. Kitchens, Iuka; Henry L. Lewis, Magnolia; Arthur Lindsey, Jr., Cleveland; Judson Lloyd, Natchez; John Long, Hazelhurst; John C. Longest, Mississippi State; Frank C. Massengill, Brookhaven; W. Ed Moak, Richton; George W. Moss, Natchez; James H. Neely, Tupelo; Carl G. Nichols, Jr., Leland; Edward R. North, Jr., Jackson; William T. Oakes, Amory; William B. O'Kelly, Weir; Louis Jennings Owens, Woodville; Brantley B. Pace, Monticello; Matthew Page, Greenville; and Octavius D. Polk, Meridian.

Others are Drs. James W. Pressler, McComb; Charles Pruitt, III, Magee; Travis Q. Richardson, Drew; Walter H. Rose, Indianola; Thomas R. Shaw, Lucedale; Marion L. Sigrest, Yazoo City; Robert Smith, Jackson; James O. Stephens, Magee; Worley K. Stewart, Pass Christian; Jim Stingily, Hazlehurst; Preston R. Stodard, Meridian; W. F. Stringer, Poplarville; T. L. Sweat, Corinth; Charles D. Taylor, Jr., Pass Christian; Horton G. Taylor, Jr., Ripley; Robert B. Townes, Jr., Grenada; Grayden A. Tubb, Fulton; L. D. Turner, Crystal Springs; James C. Waites, Laurel; J. E. Warrington, Shelby; Paul W. Warrington, Cleveland; J. S. Weatherall, Moss Point; Eugene F. Webb, Itta Bena; W. Boyce White, Laurel; Thomas B. Whitehead, Columbia; Dayton E. Whites, Lucedale; E. L. Whitfield, Florence; Charles N. Wright, Jackson; and James B. Yeldell, Jr., Greenville.

Dr. J. Ed Hill Is Doctor of the Year Finalist

A MSMA member, Dr. J. Ed Hill of Hollandale, was one of eight finalists for the Doctor of the Year award sponsored by the American Academy of Family Physicians with the staff of *Good Housekeeping* magazine. The Mississippi Academy of Family Physicians nominated Dr. Hill.

Good Housekeeping announced the winners in its October issue.

"I'm flattered and surprised," Dr. Hill said. "I didn't expect to be a finalist."

Dr. Hill, who earned the M.D. at the University of Mississippi Medical Center in 1964, is a UMC clinical instructor in family medicine and a preceptor for the Department of Family Medicine.

"I just teach medical students what I do," he said,

"no didactic teaching. I consider teaching a prime responsibility of physicians, and I enjoy it."

A native of Vicksburg, Dr. Hill wanted to practice in a rural area which had no medical facility "to see if we could build one." After four years as a general medical officer in the U.S. Navy, he and three other family practitioners chose Hollandale. At that time the delta town had been without a doctor for several months.

With a keen eye on the needs of his adopted county, Dr. Hill was the prime mover in establishing a nurse-midwifery service which he believes has played a key role in lowering county infant mortality rates.

"The great need to expand maternal-infant health care was not being met simply because of health manpower shortages. Nurse-midwifery seemed to offer an approach which would put everyone's talents to best use."

When Dr. Hill finished medical school, there was no family medicine residency at the Medical Center, and the few similar programs across the nation were scattered and immature.

If he had graduated 10 years later, he says, he "knows" he would have chosen a family medicine specialty.

"The only way we will ever meet our state health care needs is to train family physicians who can treat fairly large segments of our population. Well trained family doctors can treat 90 per cent of Mississippi's health problems. That puts our other specialists to better, more efficient use."

Mississippi still has the lowest physician-patient ratio in the nation, he said, and "in rural areas, the shortage is unbelievable."

What would he tell other young physicians about settling in Mississippi's rural areas where they're most needed?

"There are some disadvantages," he said. "You work more hours, have more night calls, and see more patients."

Obviously Dr. Hill believes the advantages outweigh the disadvantages. "I have no plans to leave here," he said.

"My advice to any physician starting out in practice is to decide first what you want to do in medicine, then move where you can do it. Don't decide where you want to live first. And if you can convince your spouse of the rightness of your decision, you've won 90 per cent of the battle in achieving permanent satisfaction."

Dr. Hill is a past vice president of the Mississippi State Medical Association.



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

- **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.
- **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.
- **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective. Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective. Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg/kg/day in rabbits and 10 mg/kg/day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.


Usage in Children. Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy. See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert[®]/25 
(meclizine HCl) 25 mg. Tablets
for vertigo*

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE **DYAZIDE®**

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:

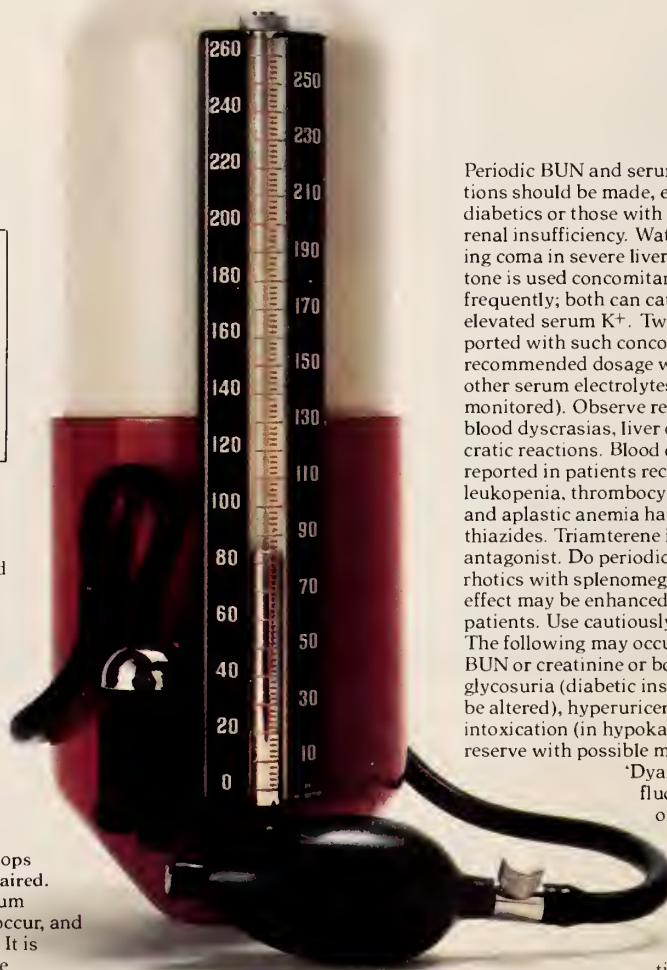
Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

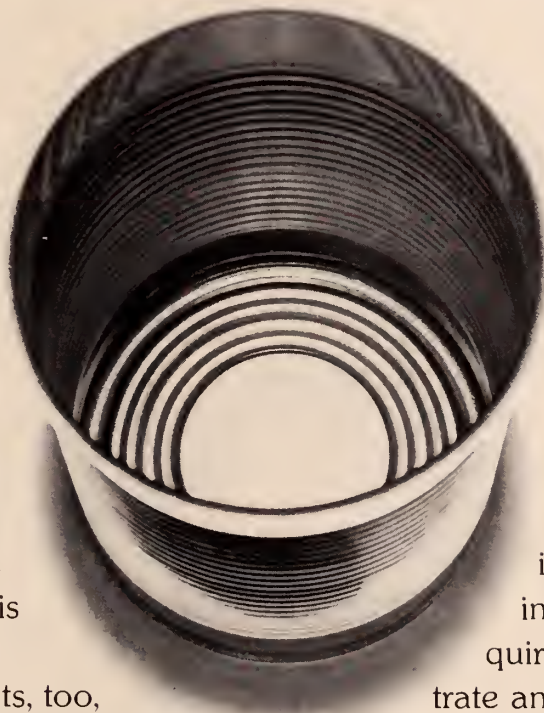
**FOR LONG-TERM CONTROL
OF HYPERTENSION.*
SERUM K^+ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company



NOW a two-piece 14oz. can for Soyalac



A two-piece can means no soldered seam. No solder means no possibility of lead contamination from the container. Soyalac is the first infant formula with this packaging innovation.

There are improvements, too, in the formulation. Soyalac now has 25% more iron than known competitive hypoallergenic milk-free formulae. In fact, the entire formula has been slightly modi-

fied to reflect the current U.S. RDA levels set by the Food and Drug Administration.

Soyalac — formula for infants on regular feeding and for those who require milk-free diets; concentrate and single strength, ready-to-use. Made from the whole soybean. I-Soyalac concentrate, made from soy isolate, with no soy carbohydrates and **no corn products**.



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LOMA LINDA FOODS
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Mount Vernon, OH 43050
(614) 397-7077

Loma Linda®

B.W.CO. HAS PUT MORE POTENCY IN THE LINE



EMPRACET® with Codeine Phosphate, 60 mg, No. 4 ©

EMPRACET® with Codeine Phosphate, 30 mg, No. 3 ©

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or codeine.

WARNINGS: Drug dependence. Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients. Caution patients that these products may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

PRECAUTIONS: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritus.

DRUG INTERACTIONS: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.

Introducing **EMPRACET®** **ċ CODEINE #4**

Each tablet contains: codeine phosphate, 60 mg (1 gr) (Warning—may be habit-forming); and acetaminophen, 300 mg.



Our new non-aspirin/ codeine analgesic for moderate to severe pain.

New peach-colored Empracet ċ Codeine #4 offers a potent alternative for patients in whom aspirin is not indicated.

Unlike compounds containing oxycodone which afford comparable analgesia, new Empracet ċ Codeine #4 gives you CIII prescribing convenience—up to 5 refills in 6 months at your discretion (where state law permits). And, prescribing by telephone is permissible in most states. Moreover, new Empracet ċ Codeine #4 has less addiction potential than does oxycodone.

For those of your patients requiring a less potent analgesic, non-aspirin Empracet® ċ Codeine #3 provides effective relief of moderate pain.

Burroughs Wellcome Co. makes codeine combination products. You make the choice.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Gallup Poll Indicates Confusion About Health

A recent Gallup Poll would seem to indicate that the American public is confused about its health care.

The poll found that most Americans rated the quality of their health care high and were satisfied with their last visit to a physician, the treatment they received and the time it took to get an appointment. Sixty-nine per cent of the public also felt confident of their ability to pay the usual costs of health care.

Other questions, however, revealed a great deal of ambivalence with respect to the public's view of health care. When queried about the need for a national health insurance program some 67 per cent of the public said yes we need one! But only 40 per cent of the public wants to pay increased taxes for such a program and hardly none want NHI if it costs more than their current private health insurance. The price tags on the present NHI Programs before congress range from \$10 to \$60 billion in new health costs.

Additionally, whereas, most of the public rates their own health care of high quality, they also think that older people and people living in rural areas get inferior care. On the other hand, elderly people and people living in rural areas believe they receive high quality care.

Federal Regulations Increase Hospital Costs

The Mississippi Hospital Association reports that the American Hospital Association has estimated the cost of just eight federal regulations will add at least \$22 to each hospital bill this year. AHA President Alex McMahon said the total hospital cost of these eight controls this year alone is about \$863 million, and will rise to nearly \$1 billion in two years.

McMahon cited the following regulations: Section 504 of the Rehabilitation act regarding improved access in hospitals for the handicapped (cost—\$460.5 million); Hill-Burton assurance reporting requirements (cost—\$14.9 million); expansion of activities of Professional Standards Review Organizations (cost—\$75 million); preparation of Medicare/Medicaid reports (cost—\$52.5 million); preparation of IRS forms for hospitals to prove they are tax exempt (cost—\$7 million); excessive testing of all non-clinical equipment (cost—\$150 million); excessive testing of emergency power generator sys-

tems (cost—\$3.2 million); multiple forms required by federal programs which could be avoided by using a national uniform billing form (cost—\$100 million).

"The nation's hospitals are finding a 'Catch 22' situation with the federal government calling for massive capital outlays to comply with these regulations while proposing hospital revenue control legislation," McMahon said.

First UMC Stokes Memorial Professor Speaks



Dr. Edward J. Cafruny, second right, professor of pharmacology at the University of Wisconsin, was the first Stokes Memorial Visiting Professor at the University of Mississippi Medical Center. The new guest lecturer program was established by the UMC School of Medicine Class of 1960 as a memorial to the late Dr. Jack Avery Stokes of Pontotoc. The professorship will rotate through the medical school departments on an annual basis. With the Stokes lecturer are second-year medical student Theodore Atkinson of Pass Christian, left; Dr. John Gibson, UMC assistant professor of radiology and a member of the Stokes committee, second left; and Dr. William O. Berndt, right, UMC professor of pharmacology-toxicology and chairman of the department. A family physician in Pontotoc at the time of his death in June 1974, Dr. Stokes earned the B.S. degree at Ole Miss in 1957 and the M.D. at the Medical Center in 1960. He interned at University Hospital.

Family Medicine Review Set

The eighth family medicine review, Session III, is set for Feb. 19-24, 1978, at the Hyatt Regency Lexington, Lexington, KY. Registration fee is \$295.00. Participants are eligible for 50 hours of AAFP credit and Category I, AMA Physician's Recognition Award Credit.

For information, contact: Frank R. Lemon, M.D., University of Kentucky Medical Center, Continuing Education, College of Medicine, Lexington, KY 40506.

Abbott Labs Honors Physicians Who Have Practiced 50+ Years

Abbott Laboratories of North Chicago, IL, made a special presentation to three Mississippi physicians who have each practiced medicine for more than 50 years. The area Abbott representative, Mr. Dave Smith, presented the Jefferson Gold Hour Clocks to Drs. Lawrence W. Long, R. C. O'Ferrall, and George Owen, all of Jackson, during the Sept. 6 meeting of the Central Medical Society. Some 200 physicians attended the meeting at Primos Northgate Restaurants in Jackson.



Dr. Lawrence W. Long, at right, is congratulated by Mr. Smith as he displays his hour clock.



Dr. George Owen, at right, receives his hour clock and congratulations from Mr. Smith.



Abbott Laboratories representative Dave Smith, at left, presents the hour clock to Dr. R. C. O'Ferrall.

Massive Vitamin Overdoses Becoming Health Problem

Massive overdose of vitamins is on the verge of becoming a major health problem in the United States.

The American Medical Association's director of foods and nutrition has warned physicians to be alert for many more cases of vitamin overdose poisonings, in the wake of legislation and court rulings that have virtually wiped out the few remaining controls over vitamins in the United States.

"The lid is off," declared Dr. Philip White in an editorial in the Oct. 17 *Journal of the American Medical Association*. Dr. White pointed to an appeals court decision last June which removed lids placed by the Food and Drug Administration on Vitamins A and D.

"The action (limiting amounts of the vitamins in non-prescription sales) was taken to protect the consumer from two potentially toxic substances. Who now is to protect the consumer from the health food entrepreneur?"

Also cited was Congressional action last year amending the Food, Drug and Cosmetic Act to restrict the FDA's authority to regulate vitamin-mineral supplements. The amendment provides that the FDA cannot control the upper limit of vitamins and other dietary supplements unless their safe use requires medical supervision. Vitamins A and D were previously controlled, but the recent court decision invalidates the FDA's protective action.

Red Blood Cells Preferred To Whole Blood in Transfusions

Indiscriminate use of whole blood transfusions is discouraged in the newly revised edition of *General Principles of Blood Transfusion*, the American Medical Association's manual on blood for the practicing physician.

The risk to the patient from transfusion is reduced considerably when only the red blood cells rather than whole blood is administered, the AMA manual points out. Use of only the red cells reduces the incidence of circulatory overload, the most common cause of transfusion injury.

Kenneth W. Sell, M.D., chairman of the former AMA Committee on Transfusion and Transplantation, points out that blood banks now provide the various components of blood that have already been separated in the laboratory—red cells, platelets, white cells and plasma. The physician may select only those components that the patient needs, and thus avoid giving whole blood much of the time.

"As with a drug with known side effects, the physician must weigh the potential danger against the expected benefit before ordering a transfusion. A blood transfusion should never be ordered or given unless it is worth the risk."

Editor of the new edition is Tibor J. Greenwalt, M.D., medical director of the blood program of the American Red Cross, of Washington, D. C.

Copies of the book (request publication OP 267) may be ordered from the AMA, 535 N. Dearborn St., Chicago, IL 60610. Price of individual copies is \$3.00.

CLASSIFIED

F.P.'s NEEDED—Growing comm. of 4000+ needs 1-2 M.D.'s 2 F.P.'s in town & 1 near by. Join exist. prac. or solo avail. Xln't rec. & econ. 60 min. from metro-cities, 57 Bed J.C.A.H. Hosp. in comm. Trade area of 12,000+ U.S. Grad. pref. Contact L. Wattier, Adm. Mem. Hosp. Inc., 104 W. 17th, Schuyler, NE 68661 (402) 352-2441.

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MPAC
TODAY

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IN CONCLUSION

Former HEW Secretary Wilbur J. Cohen told the AMA's National Commission on the Cost of Medical Care that as health care costs rise, the public likes NHI better because people believe it will reduce their expenses. National health insurance "will only redistribute the cost," Cohen said. He pointed out that the administrators of any NHI plan will face criticism because of the public's high expectations, adding that health costs will continue to rise, just as in other countries. CCMC was established by AMA to appraise all factors leading to rising costs and to review options.

A 1977 Ohio statute provides that each school or college of medicine supported in whole or in part by the state shall create an office of geriatric medicine within a department, or, in the alternative, establish a separate department of geriatric medicine. The dean is to appoint a faculty member to be responsible for incorporating subject matter into existing curriculums. The geriatrics department or office also has to provide clinical and research experience where it is considered necessary and appropriate.

Mississippi physicians should be alert to office visits by Drug Enforcement Agency agents posing as truck drivers, traveling salesmen, et cetera, and seeking prescriptions for amphetamines or other stimulant drugs "until I can get home to my family physician." The House of Delegates at the recent 109th Annual Session adopted the following statement regarding stimulant drugs: "...Prescribing of amphetamines and other stimulant drugs should be limited to specific, well recognized medical indications...."

A report in The Sciences has described the effects of a national shortage of non-human primates in the development and continuation of many essential health and bioscientific programs in this country. Richard D. Smith writes that laboratory prices of some monkey species have multiplied more than tenfold since 1970, and other species are no longer available to research at any price. He provides a summary of factors leading to the primate shortage, including discussion of U.S. and international regulations on importation and breeding.

A "Labor-Management Group" composed of top labor and business officials and co-chaired by AFL-CIO President, George Meany and G.E. Chairman, Reginald Jones has suggested limiting medical malpractice claims and expanding community health planning as a means of cutting climbing health costs. Other suggestions by the group included promoting second opinions for elective surgery, reviewing length of stays in hospitals, using more doctors' assistants to perform routine procedures and promoting Health Maintenance Organizations (HMOs).

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

~~Analyze~~

December 1977

Journal of the
State Medical
Association

Mississippi

BALCONY



Contents:

Sporotrichosis

The Mississippi
Physician as an Expert
Witness

Gallium Scanning in
Neoplastic Disease

A character all its own.



Valium (diazepam) is a benzodiazepine with a character all its own.

Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium[®] (diazepam)[Ⓢ]

2-mg, 5-mg, 10-mg scored tablets
**a prudent choice in psychic
tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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Unnecessary Surgery Debate Continues

A congressional investigation of whether there is too much surgery has boiled down to a question of whose study to believe and whose interpretation is correct. Rep. John Moss (D-Calif.), chairman of the House Commerce Subcommittee on Oversight, insists there is far too much surgery despite protests from many physicians and evidence from studies that his contentions are overblown.

Moss attacked the conclusions of a study headed by Ralph Emerson, M.D., president of the New York State Medical Society, that less than one per cent of major operations are being performed with less than usually accepted indications.

Moss and his subcommittee have been relying on another study which found that 17 per cent of surgery is not required, extrapolating that there are 2.4 million unnecessary operations yearly and 11,900 deaths from these procedures.

Meanwhile in a related action the Department of H.E.W. has urged Medicare and Medicaid recipients to seek a second opinion before elective surgery. H.E.W. Undersecretary, Hale Champion, testifying before Moss' committee stated that one reason for

increasing unnecessary surgery is because "there are many thousands of more surgeons" than we need. Champion cited tonsillectomies, hysterectomies, and cholecystectomies as operations where second opinions were especially needed.

Medicare-Medicaid Fraud Penalties Are Increased

President Carter has signed into law stiff penalties for providers who are found guilty of fraud in the Medicare and Medicaid programs.

The new law levies felony penalties to a maximum \$25,000 fine and five years in prison replacing the misdemeanor penalties of up to a \$10,000 fine and one year in prison.

The bill, passed overwhelmingly by Congress and sent to the White House, is aimed at providers and retains misdemeanor penalties for recipients convicted of defrauding the programs. It was the first major health bill of the Carter administration to become law.

Providers found guilty of fraud and abuse will be treated as felons and punished by up to five years in jail and/or a fine up to \$25,000. Previous law considered such violations as misdemeanors rather than felonies.

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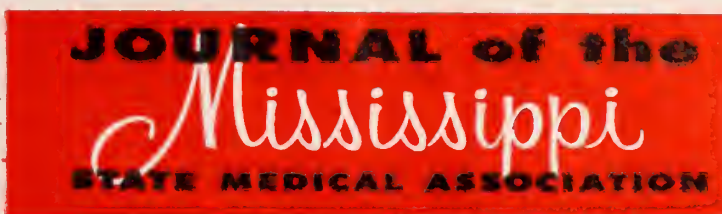
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Volume XVIII

Number 12

December 1977



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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (Publication No. 284800) is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$15.00 per annum; \$2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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ISSN 0026-6396

Alcohol Tax Support Is Needed

A concerted effort will be required this year to extend the alcohol tax bill passed by last year's Mississippi Legislature, Jim Brantley, attorney for the Department of Mental Health, told an October meeting of the Alcohol Abuse Advisory Council.

The bill, which levied a three per cent tax on the sale of alcoholic beverages to provide funds for statewide alcoholism treatment, was passed in the final moments of the 1977 session of the legislature. However, a final compromise on the bill required that it be repealed Aug. 1, 1978, after a year's existence. The legislature, which convenes in January, will review the bill and the progress made under it to decide whether the tax will be continued.

Brantley pointed out the possible difficulty in convincing the legislature to continue the tax. The tax did not go into effect until Aug. 1, 1977, and it was Oct. 1 before any of the funds reached the Division of Alcohol and Drug Abuse, which is responsible for establishing the treatment services provided by the tax money. That leaves only three months before the legislature convenes to make enough progress in establishing services to impress the legislature to con-

tinue.

The implementation of treatment services is in full swing, and it is projected that six halfway houses for alcoholics will be open in different areas of the state by December. However, many services are still only in the planning stages.

Dial Access Is Expanding

Over a period of seven years and thousands of telephone calls, the innovative Dial Access System has given physicians throughout the nation answers for cancer. Pioneered by M. D. Anderson Hospital and Tumor Institute and the Southern Medical Association, the program now is being expanded to include other kinds of medical information.

Simply by making a toll-free phone call, physicians may at any time receive tape-recorded expert advice on any one of 350 topics related to the treatment of 25 types of neoplastic disease. Each six-to-eight minute message was written by an authority on the subject. It is narrated either personally by that authority or by a professional announcer. Every message includes three references.

Dr. G. Thomas Jansen, Jr. of Little Rock, AR, Southern Medical Association president, says that similar programs are coming on-line for three other medical areas of interest: infectious diseases, arthritis and rheumatism and psychotherapeutics.

"These programs are being developed to start in January 1978, Dr. Jansen says. "Also, manuscripts are in preparation in three more areas, pulmonary disease, diabetes and cardiovascular disease."

M. D. Anderson Hospital and Tumor Institute of Houston, TX, has been the primary sponsor of the cancer series since March 1970 when the program began. Financial assistance is being provided by a grant from the National Cancer Institute.

Dialing the toll-free number contained in the catalogue, the physician tells the operator his or her name, profession, address and the number of the recording he or she wants to hear. Six WATS (wide area telephone system) lines, interswitchable, are connected to cartridge tape players.

Within 15 seconds the physician hears the voice of a physician. During the transaction of this call the physician may also arrange a consultation with the specialist and can additionally request a written copy of the message. Several weeks later a questionnaire will arrive by mail, requesting the physician's analysis of the information received and the program itself.

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Please see reverse side for summary of product information.



For recurrent attacks of urinary tract infection in women

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Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

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- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

British Bed Hijacker Gets Operation

Rita Ward, a Northampton, England, housewife, faced with a two-to-three-year wait for removal of a painful, diseased gallbladder, recently hijacked a hospital bed and refused to leave until she had her operation. For Mrs. Ward, the imposed delay was devastating. She claims she tried to do the operation herself and then attempted suicide before marching into the hospital, climbing into an empty bed and demanding her operation.

National Health Service officials admit that Ward's dramatic act highlights health service problems, but they don't expect any more "hijackings" from the 590,000 patients on a waiting list that grows at one per cent per year. The government must allocate health care funds which are insufficient to meet existing needs. To further aggravate this problem, Parliament voted to "phase out" the 3,000 private beds in the system's 400,000 beds. The waiting lists are long, with delays of six months in the London area to four years in parts of the sparsely populated Midlands and South Yorkshire. Northampton's Dr. Chapman says it is not unusual to have 400 patients awaiting treatment with 200 requiring major surgery. "Routine cases" like Mrs. Ward's must wait two to three years. In fact, Dr. Chapman's "urgent" list is six months long.

Lung Disease Course Set for New Orleans

The 3rd Annual New Orleans International "Mardi Gras" supercourse on lung disease will be Jan. 23-27, 1978, at the Braniff Place Hotel, announced Howard A. Buechner, M.D., the course chairman.

The annual program is sponsored by the American Lung Association of Louisiana, and its medical section, the American Thoracic Society of Louisiana.

Supercourse is accredited by the American Medical Association in Category I, the American Academy of Family Physicians, and the American Association for Critical-Care Nurses. According to Dr. Buechner, the five-day program consists of three separate lung disease courses running concurrently during the week.

Dr. Buechner says advance tuition for the program is \$185.00. Additional information and complete programs are available from the ATS of Louisiana, 333 St. Charles Ave., Suite 500, New Orleans, LA 70130.

NHI Road Show Performs in Jackson

Jackson was the scene last month for a national health insurance forum sponsored and conducted by the Department of HEW in each state.

The NHI scenario orchestrated by HEW consisted of a one day program the morning of which was devoted to a panel of "health experts" to discuss Mississippi's health needs. Neither the Mississippi Hospital Association nor the Mississippi State Medical Association was invited to have representatives on the "health experts" panel.

As expected, some of the often repeated statements came from the experts—"the federal government should finance and administer a national health program for everyone," "poor people can't get health care"—and so on.

Apparently forgotten was the fact that the federal government has been administering a national health program and there has been a federal/state program to provide health care for the poor for several years. The programs are known as Medicare and Medicaid and both are in trouble from the standpoint of cost, benefits and coverage.

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TABLETS, 20 mg.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose, Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose, Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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NEWSLETTER

December 1977

Dear Doctor:

Physicians are reminded to mail CHAMPUS claims to: CHAMPUS, P.O. Box 3500, Jackson, MS 39207. MSMA continues to receive such claims, thus delaying their transmission to Blue Cross-Blue Shield for processing. The association ceased functioning as CHAMPUS fiscal intermediary for professional services in Mississippi earlier this year. Blue Cross-Blue Shield of Mississippi, Inc. now serves as fiscal intermediary for hospital and professional services in Mississippi and Louisiana.

As Journal MSMA went to press, the Mississippi Medical Fraternal and Educational Society was issuing its first professional liability coverage policies to members. MMFES provides lowest cost coverage available in Mississippi and is the only source for both claims made or occurrence coverage.

HEW Secretary, Joseph Califano, recently announced the launching of "Operation Commonsense", a project to review and rewrite HEW's existing regulations "to make them clearer and less burdensome and to eliminate provisions that actually impede the implementation of our programs." He said the review will take five years perhaps indicating how unclear and burdensome most HEW regulations have become.

The American Medical Association has won a major victory in the deletion from H.R. 6575 (hospital cost control legislation) of a provision that would have extended Certificate of Need into the physician's office. The administration's hospital cost control legislation is expected to be on the congressional burner again when Congress convenes in January.

A record of all Medicare payments to any physician, assigned or unassigned, must be prepared by the Medicare Part B Carrier on an annual basis and made available for public inspection. The Social Security Administration has directed that such annual lists be prepared under the "Government in Sunshine Act," which is Public Law 94-609.

FDA Commissioner Donald Kennedy has repeatedly announced that there is no such thing as a drug lag and now has promised to end it. "Some historical inflexibilities in our drug laws may be contributing some unnecessary delay and procedural stiffness to the new drug approval process, and that is part of the reason we are proposing the first major revisions in the drug laws since the Kefauver--Harris amendment."

Sincerely,



Nola Gibson
Managing Editor

Surgical Forum Slated for March

Mississippi surgeons will join an international guest faculty in Jackson Mar. 9-11, 1978, for the Surgical Forum.

The seminar, sponsored by the University of Mississippi School of Medicine and the Medical Center Division of Continuing Health Professional Education, will be at the Holiday Inn Downtown.

Coordinating the event are Dr. James D. Hardy, UMC professor of surgery and department chairman, and Dr. William O. Barnett, UMC professor of surgery.

Guests include Walter F. Ballinger, M.D., Bixby Professor of Surgery and head of the department, Washington University School of Medicine, St. Louis; Oliver H. Beahrs, M.D., professor of surgery, Mayo Medical School, Rochester; J. Lynwood Herrington, Jr., M.D., associate clinical professor of surgery, Vanderbilt University Medical School, Nashville; William P. Longmire, Jr., M.D., professor and chairman, department of surgery, University of California, The Center for The Health Sciences, Los Angeles; William C. McGarity, M.D., chief of surgery, Emory University Hospital, Atlanta; Norman D. Nigro, M.D., clinical professor of surgery, Wayne State University, Detroit;

John E. Ray, M.D., head of the department of colon and rectal surgery, Oschner Clinic and clinical associate professor of surgery, Tulane University School of Medicine, New Orleans; H. Harlan Stone, M.D., professor of surgery, Emory University School of Medicine, Atlanta; Watts R. Webb, M.D., professor and chairman, department of surgery, Tulane University School of Medicine, New Orleans; Professor R. B. Welbourn, Royal Postgraduate Medical School, University of London, Hammersmith Hospital, London, England; Claude E. Welch, M.D., clinical professor surgery emeritus, Harvard Medical School, Boston; and George D. Zuidema, M.D., Warfield M. Firor professor and director, section of surgical sciences and surgeon-in-chief, The Johns Hopkins Hospital, Baltimore.

Attendance is by invitation and advance registration is required. Enrollment is limited and applications will be accepted in the order received. The \$150 registration fee includes seminar tuition, lunch on Thursday and Friday and a reception Friday evening.

Motel reservations should be made directly with the Holiday Inn Downtown in Jackson.

For additional forum information write: Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson 39216.

MARCH 31-APRIL 4, 1978

41st Annual

New Orleans Graduate Medical Assembly

Fairmont Hotel, New Orleans

Meeting Theme: "The High Risk Patient"

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for the pain for the pathogens

□ **Early relief of painful symptoms** such as burning and pain associated with urgency and frequency.

*Nonobstructed; due to susceptible organisms



□ **Effective control of susceptible pathogens** such as *E. coli*, *Klebsiella-Aerobacter*, *Staph. aureus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

□ **Appropriate antibacterial therapy:** up to three days therapy with Azo Gantanol, then 11 days with Gantanol[®] (sulfamethoxazole), 0.5 Gm tablets.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura,

hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); G.I. reactions (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); CNS reactions (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE **DYAZIDE®**

Each capsule contains 50 mg. of Dyrenium[®] (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:

Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

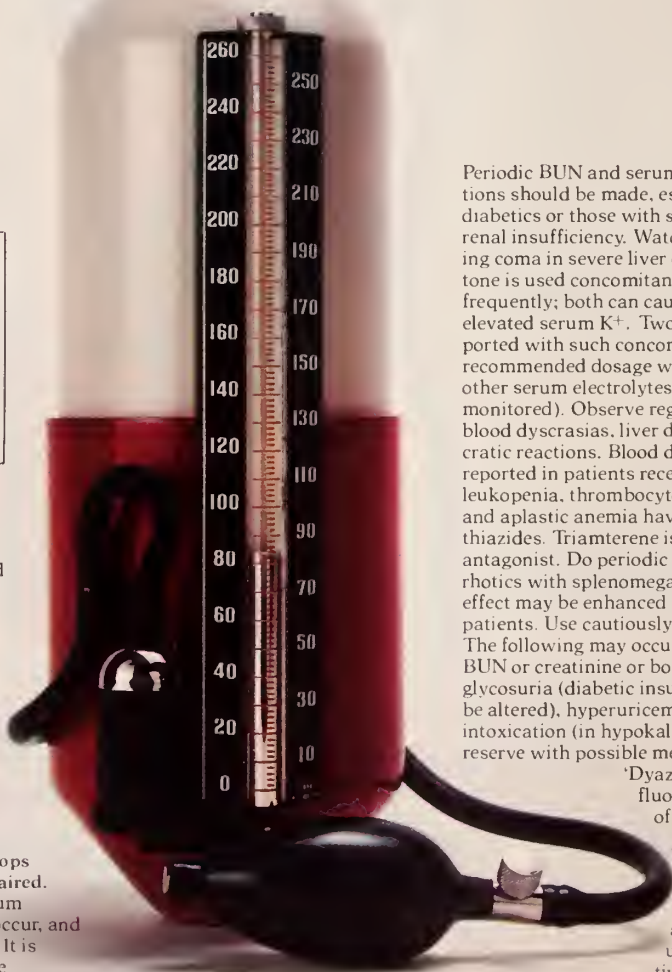
nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

**FOR LONG-TERM CONTROL
OF HYPERTENSION*
SERUM K⁺ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

SK&F CO., Carolina, P.R. 00630

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THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION

Neosporin[®] Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin[®] Ointment (polymyxin B-bacitracin-neomycin).



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Research Triangle Park
North Carolina 27709

Neosporin[®] Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin[®] brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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Women Witnesses.**

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**Wanted Movies of Ceremony,
But Both Factions Are**

WASHINGTON, Aug. 26, 1920—
The struggle for woman



**VOTERS
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TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

**President Hails 'Great
Instrument of Peace,'
Insists It Be Used**

HISTORIC LANDMARK

**Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain**

Social Security Bill Is Signed; Gives Pensions to Aged, Jobless

**Roosevelt Approves Message Intended to Benefit 30,000,000
Persons When States Adopt Cooperating Laws—He Calls
the Measure 'Cornerstone' of His Economic Program.**

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

**Amendment to Constitution
is Sent to House, Where
Passage is Expected**

**WASHINGTON, March 10,
1971—The Senate approved
today 94 to 0 and sent to**

WASHINGTON, Aug. 14, 1935—
The Social Security Bill, providing
a broad program of unemployment
insurance and old age pensions
and counted upon to benefit some
20,000,000 persons, became law
today when it was signed by President
Roosevelt in the presence of those
chiefly responsible for passing it
through Congress.

Mr. Roosevelt called the measure
"the cornerstone of the structure
which is being built to give every
man's example of the new
right to life, liberty and the pursuit of happiness."

COMPL

SIGNED the Draft Ends Nov

"If we fail to use it," he declared
to the solemn final meeting of the
delegates, "we shall betray all of
those who have died in order that
we might meet here in freedom and
safety to create it."

"If we seek to use it selfishly—for
the advantage of any one nation or
any small group of nations—we
shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the
auditorium of the War Memorial
Opera House, built in memory of
sons of the Golden Gate city who
gave their lives in the first World
War, in which he himself served,
seemed to give unconscious expression
to the solemn feeling of the
occasion when, at the outset of his
speech, he interpolated the words,
half a hope, half a prayer:

"Oh, what a great day this can
be in history!"

Just before the plenary session
the President accompanied the
eight United States delegates to

**WASHINGTON, Jan. 27,
1973—"With the signing of
the peace agreement in
Paris today, and after receiving a report from the
Secretary of the Army that
he foresees no need for**



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

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Mississippi's Unique Psychiatric Hospital.

Riverside Hospital is unique in Mississippi.

As a privately owned 56-bed short term care facility for treating patients with psychiatric illness or emotional problems, it is the only hospital of its kind in the state.

Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

For additional information contact: John R. Reedy, Executive Director.

Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030



DATELINE

School Health Education Urged

Jackson, MS - One of the 1978 legislative goals of MSMA is to seek legislation requiring implementation of health education programs in the public schools in Mississippi.

The recently drafted association proposal would require formulation and implementation of sequential health education programs by all local school boards and creates a health education advisory committee. MSMA believes effects of life-style and environment decisions on health should be taught at an early age.

FTC Wants to Control Medical Practice

Washington, DC - Determination of the Federal Trade Commission to attack medical practice was reiterated when FTC chairman Michael Petschuk recently told an FTC-sponsored conference on "Competition in the Health Care Sector: Past, Present, and Future," that the practice of medicine "is one of the last strongholds of private entrepreneurship," that physicians practice with "rather remarkable independence" and said he had doubts about self-regulation by health professionals.

Surgery May Be Safe Without Transfusions

Houston, TX - Cardiovascular operations can be performed safely without blood transfusions, report Drs. David Ott and Denton Cooley in JAMA. They report on a 20-year experience of surgery performed on 542 Jehovah's Witness patients at Texas Heart Institute. Early mortality rate was 9.4% and only three of the 51 deaths were related directly to loss of blood. Drs. Ott and Cooley contend that patients can undergo major operations with an acceptably low risk.

Jehovah's Witnesses Release Booklet

Brooklyn, NY - The Watchtower Bible and Tract Society and the governing board of Jehovah's Witnesses have published a booklet, "Jehovah's Witnesses and the Question of Blood." This booklet covers the religious basis for their position as well as the ethical, medical and legal problems raised by this view. The tract stresses that the objection to accepting blood is not primarily a medical one; it is a Biblical or religious objection.

Patient Education Enhances Medical Care

Cleveland, OH - A new kind of patient education, one that's specifically tailored to the patient and his or her individual health problems and needs is now in use in more than 70 group clinics, hospitals and other health care centers, says P. G. Skillern, M.D., of the Cleveland Clinic. In these institutions, there is a formally designated patient education center, a patient educator, and patient education programs. Patients pay from \$10-15 for their specific audiovisual filmstrip program.

Medical Center Plans Gastroenterology Update

The University of Mississippi Medical Center hosts a "Gastroenterology Update" course Mar. 30, 31, and April 1.

The three-day program on general topics in digestive diseases will bring the practicing physician up-to-date on new advances and concepts in gastroenterology.

Guest faculty will include Dr. H. Worth Boyce, Jr., professor of medicine and chief, section of gastroenterology, University of South Florida College of Medicine, Tampa; Dr. Donald O. Castell, captain, medical corps, United States Navy, professor of medicine, Uniformed Services University of the Health Sciences, Chief of Medicine, National Medical Center, Bethesda; Dr. John T. Galambos, professor of medicine, and director of the division of digestive diseases, Emory University, Atlanta; Dr. Basil I. Hirschowitz, professor and director, division of gastroenterology, University of Alabama, Birmingham; Dr. John T. Sessions, Jr., professor of medicine, division of digestive diseases and nutrition, University of North Carolina, Chapel Hill; and

Dr. Robert G. Smith, III, chief, surgical service, VA Hospital, Atlanta.

Coordinator for the course, sponsored by the UMC School of Medicine, Department of Medicine, Division of Digestive Diseases, and the Medical Center Division of Continuing Health Professional Education, is Dr. James L. Achord, professor of medicine and director of the division of digestive diseases.

Registration fee is \$150 for any or all portions of the program. The course meets the requirements for 18 credit hours in Category I of the Physician's Recognition Award of the American Medical Association and the American Academy of Family Physicians has approved the course for 18 credit hours. Conference headquarters is the Ramada Inn Coliseum, Jackson.

Voluntary Cost Containment Is Sought

Spokesmen for the American Hospital Association, The Federation of American Hospitals, and the American Medical Association have accepted a challenge issued by Congressman Dan Rostenkowski (D-Ill.) to develop a voluntary hospital and health care cost containment program.

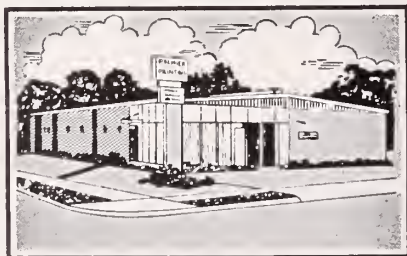
President Alex McMahon of the American Hospital Association, Director Michael Bromberg of the Federation of American Hospitals, and Executive Vice President James H. Sammons, M.D., of the AMA said the three organizations, at the instruction of their respective officers, would begin to organize a national steering committee of hospital people, doctors, insurers, consumers and others with a major stake in hospital cost containment.

"We will ask this committee, which we expect to meet within the next several weeks, to develop the goals and mechanisms, first, of a voluntary program to reduce the rate of increase in hospital costs, and, second, of a voluntary program to reduce the rate of increase in health care costs as a whole. We will also encourage the development of similar steering committees at the state level to implement these programs."

"It is our strong belief that our efforts will be successful, and it is our hope that it will then become unnecessary to impose a new, bureaucratic control system that could impair existing efforts to provide better health care for all Americans at an acceptable price."

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MEETINGS

National and Regional

American Medical Association, House of Delegates Interim Mtg., Chicago, Dec. 4-7, 1977; Winter Scientific Mtg., Miami Beach, Dec. 10-13, 1977. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

22nd annual Tri-State Thoracic Society, sponsored by Lung and Thoracic associations of Mississippi, Louisiana and Alabama, Jan. 6-7, 1978, Biloxi Hilton Hotel.

Louisiana-Mississippi Ophthalmological & Otolaryngological Society, March 30-April 1, 1978, Broadwater Beach Hotel, Biloxi, MS. Ben A. Davis, Jr., CAE, Executive Secretary, P. O. Box 12314, Jackson, MS 39211, telephone (601) 956-7787.

Cardiopathy of Aging IV (Heart disease in the elderly patient), Little Rock, AR, May 16-17, 1978, by the Veterans Administration, University of Arkansas College of Medicine, Council on Clinical Cardiology and Tri-State Scientific Sessions of the American Heart Association. Program Director J. E. Doherty, M.D., 300 E. Roosevelt Rd., Little Rock, AR 72206.

State and Local

Mississippi Academy of Family Physicians, Annual Meeting, July 12-15, 1978, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 110th Annual Session, May 1-4, 1978, Jackson. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Henry McCrory, Secy., P.O. Box 340, Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. G. L. Arrington, Jr., Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1167, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Charles A. Osborn, Secy., 207 Meadow Lane, Eupora 39744. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. George Walker, Secy., 102 W. Lampkin St., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Clyde Gunn, Jr., Secy., P.O. Drawer G, Moss Point 39563. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Thomas Blake, Secy., 424 S. 13th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

New Orleans Hosts Southeastern Surgical Congress

New developments in major areas of surgery will be spotlighted at the 46th annual assembly of the Southeastern Surgical Congress, Feb. 19-22 at the Fairmont Hotel in New Orleans.

Some 2000 surgeons, surgical nurses and medical and nursing students are expected to attend, according to Dr. Thad M. Moseley of Jacksonville, president; and Dr. A. Hamblin Letton of Atlanta, director.

The 13 southeastern states, District of Columbia and Puerto Rico will be represented.

Nationally-known surgeons invited as guest speakers are: Dr. Oliver H. Beahrs, head of surgery, Mayo Medical School and Clinic; Dr. Hiram C. Polk, Jr., chairman, department of surgery, University of Louisville School of Medicine; Dr. Erle E. Peacock, Jr., chairman, department of surgery, Tulane University School of Medicine; Dr. Robert E. Hermann, staff surgeon, the Cleveland (Ohio) Clinic; and Col. (Dr.) Basil A. Pruitt, Jr., director, Army Institute of Surgical Research, Brooke Army Medical Center, Ft. Sam Houston, TX.

Dr. Alexander Heard, chancellor of Vanderbilt

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University, will address the opening session Monday morning.

Dr. John L. Ochsner, director of New Orleans' Ochsner Clinic, is coordinating the nurses' educational program to run concurrently with the surgeons' scientific sessions.

A postgraduate course for surgeons on infections will be chaired by Dr. William R. Sandusky of the University of Virginia Medical School. Both scientific and postgraduate sessions are accredited for the American Medical Association's continuing education award.

Dr. Watts R. Webb of New Orleans is chairman of local arrangements.

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Counsel to Authors

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly),

and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for up to four illustration engravings. More are not permitted unless voted on by two editors and extra costs must be absorbed by the author.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

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ORIGINAL PAPERS

Sporotrichosis

HORTON G. TAYLOR, JR., M.D.
Ripley, Mississippi

IN 1976 THERE were some 14 cases of sporotrichosis in Mississippi amongst forestry and nursery workers.¹ One of these cases was seen in my practice in Tippah County.

R. M. H. is a middle-aged male who presented in early 1976 with red, raised nodules on his forearm where he had previously been injured by a scratch from a seedling he was planting. This lesion is shown in Figure 1.

Initially, sporotrichosis was considered on the basis of clinical history and the painless nature of these lesions. However, therapy was started with an anti-staphylococcal penicillin. After one week there was no improvement but some liquefaction of several lesions was noted. At this point bacterial cultures and cultures with Sabouraud's agar were carried out. The bacterial cultures showed no growth but the Sabouraud's agar grew out the classic picture of *Sporotrichum schenkii* as shown in Figure 2.

After similar growth on Sabouraud's agar in the office of a consulting dermatologist in Memphis, TN, the patient was started on a course of therapy with potassium iodine. Photographs of the resolving lesions are shown at one month and two month intervals in Figures 3 and 4.

After two months of potassium iodide therapy, 15 drops three times a day, the nodules continued to resolve to complete healing. At this point a concise review of sporotrichosis, published in *Tree Planter's Notes* in 1960 by Theodore C. Doege, M.D., was consulted and is presented below.²

Sporotrichosis

Sporotrichosis is a disease of man, plants, and animals, caused by fungus *Sporotrichum schenkii*. In most cases of human infection, only the skin and lymph channels beneath the skin are infected. The fungus is widespread in nature, and has been found

in the soil, as well as on flowers, vegetables, shrubbery, and bark. It survives extremes of temperature and altitude and, although it is found in all sections of the U. S., most infections are reported from the Midwest. Although anyone may be infected, the disease occurs most often in gardeners and farmers, and it may be considered an occupational disease. It probably cannot be transmitted from person to person.

A recent case of sporotrichosis with photographs is presented along with a brief review of this disease from Tree Planter's Notes. The author hopes this paper will aid other Mississippi physicians in making this diagnosis in appropriate cases.

The typical infection follows an abrasion, scratch, prick, or bite through which the spores of the fungus are introduced beneath the skin. In one to four weeks following exposure, a small, painless, pus-containing blister is formed, which may open, become raw, and slowly enlarge. Areas distant from the point of contact are infected as the fungus spreads through lymph vessels, which may become visibly reddened and hard. Nodules may form along the infected lymph channels, which lead away from the point of initial infection. Lymph glands in the armpit or elbow may become enlarged and sore. The disease is slowly progressive if untreated, and through the bloodstream fungi may be carried to the abdominal organs and the uninvolved skin. Since the disease may be simply and adequately treated, it is rarely fatal.

The diagnosis is made by growing and identifying the fungus in the laboratory. Material obtained



Figure 1



Figure 2



Figure 3



Figure 4

from the initial ulcer or one of the small opened nodules is placed on a specific growth medium (Sabouraud's agar) and the characteristic macroscopic and microscopic appearances of the fungus are noted. A special skin test may be used to confirm infection, or an animal may be injected with infected pus and the organism demonstrated microscopically after autopsy.

Iodines given by mouth specifically cure this infection. They are usually given in the form of potassium iodine solution, five drops three times daily, the dose being increased by one drop to a final dose of 35-50 drops three times daily. Penicillin and other antibiotics are not helpful or curative, but occasionally localized radiation to an ulcer may aid healing. Stilbamidine may be tried if the iodides cannot be prescribed.

Healing with only a scar remaining may be expected within one to four months after iodide therapy

is started. Such scars may be large and disfiguring, especially if infected sores are allowed to progress and enlarge for a long period before being treated. To assure total healing, iodides should be continued for one month after healing is considered complete.

It is hoped by presenting this case report that other Mississippi physicians will be alerted to the possibility of this fungal infection occurring amongst nurserymen and especially those handling pine seedlings. ★★★

111 West 1st Street (38663)

The author expresses appreciation to Fox Miller, M.D., Memphis, TN, and Theodore C. Doege, M.D., University of Illinois Medical Center, Chicago.

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1. Personal communication with Mississippi Forestry Service.
2. Doege, Theodore: *Tree Planter's Notes*, No. 41, April, 1960.

'Tis the season for kindling the fire of hospitality in the hall,
the genial fire of charity in the heart.

WASHINGTON IRVING



The staff and officers of MSMA wish for all members and their families a most joyous holiday season and a happy and healthy year in 1978.

The Mississippi Physician as an Expert Witness—Must He Accept Token Compensation?

GARY J. BYRD, M.D.

Houston, Texas

FOR THE PHYSICIAN who is a busy clinician, an appearance in court is usually disruptive and may be quite distressing. With the constantly increasing number of medically related lawsuits, the probability that a Mississippi physician will be subpoenaed to appear as an expert witness in a court of law is markedly increasing. A specialist in legal medicine could be well prepared for this task by his training and experience. However, in the large majority of such situations, the physician being called is primarily a clinician who may not be familiar with the role of the expert witness nor with his basic rights while serving in that role.

The role of the expert witness will be defined; the legal treatment of expertise will be discussed; the basic rights of all physicians under the United States Constitution will be given; the current status of the law in Mississippi will be presented; and the various alternatives available to the Mississippi physician who is subpoenaed to testify as an expert witness will be examined.

When an individual is called to court to serve as a witness, it is usually in the capacity of a fact witness. As a fact witness he responds to questions which have been presented to him by the trial attorneys in the areas of disputed factual matters. Generally fact witnesses may not speculate nor may they express an opinion. The role of the expert witness is substantially different both in that he must be qualified by special training, experience, or knowledge in order to be an expert witness, and as an expert witness, he may be called upon to do one or more of the following: (a) express professional opinions; (b) examine facts and come to conclusions; (c) respond to hypothetical questions; (d) explain technical procedures to the judge or to the jury; (e) insist upon clarification of a question if the question is ambiguous; and (f) include discussion

and explanation in an answer when a yes or no answer would not suffice to properly answer the question.

The author defines the role of the expert witness and discusses the legal treatment of expertise and the basic rights of all physicians under the U. S. Constitution. The current status of Mississippi laws is presented along with the various alternatives available to a Mississippi physician who is subpoenaed to testify as an expert witness.

Since the testimony of a medical expert witness is based upon his lengthy education, special training, and clinical experience, this testimony may be considered to have all of the characteristics of property. Property has been judicially defined to include every interest anyone may have in any and everything that is the subject of ownership by man, together with the right to freely possess, use, enjoy, or dispose of the same.¹ As to the controls upon the proper disposition of this property, perhaps no court has delineated it more aptly than the Pennsylvania Supreme Court which stated: "the private litigant has no more right to compel a citizen to give up the product of his brain than he has to compel the giving up of material things."² If indeed, medical expert testimony is attended with the character of property, then to require the presentation of that testimony without an offer of compensation considered reasonable by the physician would be equivalent to the deprivation of property without due process of law. An action of this type would clearly violate the rights of the Mississippi physician as secured under the 14th Amendment to the United States Constitution. From a somewhat different perspective should a physician simply decline to testify as an expert witness on the grounds that he does not care to work under the circumstances, he can find support for his position in

From the Department of Psychiatry, Baylor College of Medicine, Texas Medical Center, Houston, TX.

the 13th Amendment to the United States Constitution which prohibits involuntary servitude and forbids the involuntary impression of an individual into the service of the state.

The question of the property rights of expert witnesses has been decided favorably by a state supreme court ruling in these 10 states: Colorado,³ Florida,⁴ Illinois,⁵ Indiana,⁶ Iowa,⁷ Kansas,⁸ New Jersey,⁹ New York,¹⁰ Pennsylvania,¹¹ and Rhode Island.¹² In each of these, the right of an expert witness to be paid for his time and knowledge was affirmed.

Under present Mississippi law, physicians who have performed autopsies or who have performed chemical analyses for criminal investigations may be subpoenaed as expert witnesses and paid a maximum fee of \$50.00 per day.¹³ Special provisions for medical expert witness fees have been made under Workmen's Compensation Law¹⁴ which allows the commission to determine the qualifications of specialists and their scale of fees as expert witnesses. Unless otherwise provided, these witnesses may receive the same fees as fact witnesses. Other than the possible exceptions described above which provide, at most, a token fee for the expert witness, there is no provision for reasonable compensation for medical expert witnesses in Mississippi law. Within the related statutes, it is stated,¹⁵ "If any person subpoenaed as a witness in any case or matter, shall refuse to be sworn or affirmed, or to give evidence, he shall be committed to prison by the court, justice, master, commissioner, referee, or other person authorized to take his testimony, there to remain without bail until he shall be sworn or affirmed or shall give his evidence."

Another statute¹⁶ states, "Every witness subpoenaed in any case, civil or criminal, shall attend, from day to day, and from term to term without further notice, until discharged by the court or by the party at whose instance he was subpoenaed, and in default thereof he shall be fined by the court not more than \$500.00, and a scire facias shall issue thereon, requiring him to appear at the next term of the court, to show cause why the fine should not be made absolute. . . ." It is of interest to note that the courts have addressed both the composition of hypothetical questions and the conditions for responding to such questions. In *Alman Bros Farms*,¹⁷ the court stated, "Generally, the form and length of hypothetical questions are within the discretion of the trial judge." In *Dickerson*,¹⁸ it had been previously held that, "It is for the witness and not the court to determine whether from the facts stated he is able to

express a scientific opinion. . . . A hypothetical question need not include all the facts in evidence, nor facts or theories advanced by opposing counsel."

If a Mississippi physician is called to be a medical expert witness by a private litigant or by the state without an offer of compensation which the physician believes to be reasonable, then he could appear in court, discharge any obligations which he might have as a fact witness and refuse to testify further. He could ethically and justly refuse to testify as an expert witness based upon his rights as guaranteed under the 13th and 14th Amendments to the United States Constitution. At this point, it is possible that he could be held in contempt of court by the trial judge.

There are two distinct categories of contempt, criminal and civil. In criminal contempt, the individual is cited for a completed transgression. In contrast, in civil contempt the individual is usually incarcerated for what he has failed to do, that is to comply with an order of the court. The incarcerated expert witness in this position, according to the language of the United States Supreme Court in *Gompers*,¹⁹ carries with him the keys with which he may unlock the jail at any time by simply yielding to the demands of the court.

This impasse may seem to offer the principled, sincere Mississippi physician no option other than the mercy of the trial court. However, he has another alternative. In order for any trial judge to legally cite an expert witness for civil contempt and order him incarcerated until he complies with a given court order, certain fundamental requirements must be met. The demands of the judge must be reasonable, and he must have specific authority in the law to make and enforce those demands. If the Mississippi physician expert witness who has been incarcerated for civil contempt should doubt that these requirements can be met or if he believes that the court order violates any of his constitutional rights, then he can test the validity of the contempt citation collaterally by application for a writ of habeas corpus. This must be immediately granted and in addition to releasing the physician from incarceration, it would establish a test case which would move the issue to a higher or appeals court for determination. In the subsequent higher court review, should it be found that any Mississippi statute or any previous ruling by a Mississippi court were in conflict with any of the basic rights of the physician as guaranteed under the 13th and 14th Amendments to the United States Constitution, then the physician would prevail. The original civil contempt citation would be

EXPERT WITNESS / Byrd

voided and the physician would then be free to negotiate a contract as to whether or not he would testify as an expert witness, and if so, for a fee deemed reasonable by the physician.

Until such a judicial precedent is established in a court of record or until the Mississippi legislature enacts appropriate legislation, the local bar societies, the medical societies, and the judiciary could design a mutually acceptable method of reasonably, fairly, and justly compensating the medical expert witness.

★★★

1200 Moursund Avenue (77030)

POSTGRADUATE CALENDAR

Jan. 9-13, 1978

EKG INTENSIVE COURSE

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education.

Coordinator: Thomas M. Blake, M.D., professor of medicine and chief of the cardiology division and of electrocardiography, University of Mississippi School of Medicine.

This five-day course is for practicing clinicians, internists and family practitioners who regularly use electrocardiography. Consisting of discussion and demonstrations, the course is designed to enhance understanding of the subject, its limitations and its applications. The role of the computer will be discussed and overall principles and perspectives will be emphasized. Participants are encouraged to bring tracings for discussion. Fee: \$150.00. Credit: 40 contact hours, 4.0 CEU, Category I, AMA; AAFP.

Feb. 14, 1978

HYPERTENSION SEMINAR

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education with support from Pfizer, Inc.

Coordinator: Herbert G. Langford, M.D., professor of medicine, University of Mississippi School of Medicine.

References

1. *Father Basil's Lodge, Inc. v. Chicago*, 393 Ill. 246, 65 N.E.2d 805.
2. *Pennsylvania Co. for Insurance v. Philadelphia*, 262 Pa. 439, 442 (1918).
3. *Lamont v. Riverside Irrigation District*, 498 P.2d (1972).
4. *Tiedke v. Fidelity and Casualty Co. of N.Y.*, 222 So.2d 206, 210 (1969).
5. Ill. Sup. Ct. R. 17-2 (5 Sept. 1961) (Impartial Medical Experts).
6. *Dills v. State*, 59 Ind. 15 (1877). (Additionally, the State Constitution states, "No man's particular services shall be demanded without just compensation.")
7. *Snyder v. Iowa City*, 40 Iowa 646 (1975).
8. *Womer v. Aldridge*, 125 P.2d 392, 1942.
9. *Reda v. State*, 308 N.Y.S.2d 558.
10. *Stanton v. Rushmore*, 112 N.J.L. 115, 169 A. 721.

JOURNAL MSMA policy allows only 10 references to be published. For a complete list of the (19) references, write to the author.

Designed for the general practitioner, this one-day seminar will emphasize advances in the treatment of hypertension. There will be a fee. Category I and AAFP credit will be applied for.

FUTURE CALENDAR

Feb. 8-10, 1978

NEWBORN SEMINAR FOR THE PHYSICIAN

University Medical Center, Jackson

Feb. 16-17, 1978

SOUTHEASTERN REGIONAL FACULTY DEVELOPMENT WORKSHOP

Holiday Inn Medical Center, Jackson

Mar. 9-11, 1978

SURGICAL FORUM V

Holiday Inn Downtown, Jackson

Mar. 15-17, 1978

NEWBORN VENTILATION

University Medical Center, Jackson

Mar. 20-31, 1978

NEWBORN CARE FOR PHYSICIAN AND NURSE TEAM

University Medical Center, Jackson

Mar. 30-April 1, 1978

GASTROENTEROLOGY UPDATE

Ramada Inn Coliseum, Jackson

April 13-14, 1978

NEWBORN RESUSCITATION

University Medical Center, Jackson

May 11-12, 1978

NEWBORN NUTRITION SEMINAR

University Medical Center, Jackson

Radiologic Seminar CLXXVI: Gallium Scanning in Neoplastic Disease

JANE A. SANDERS, M.D., and W. MEL. FLOWERS, JR., M.D.

Jackson, Mississippi

SINCE THE EARLY days of nuclear medicine, researchers have been concerned with finding tumor-seeking scanning agents. Early diagnosis, definitive staging, more precise therapy, and increased cure rates are the obvious goals. The perfect radiopharmaceutical has yet to be found. The best available to date is gallium-67 citrate, discovered by Edwards and Hayes in 1969.

Gallium-67 has been studied by hundreds of researchers around the world. Two of the most important investigations are the multi-university study of Langhammer and associates in Europe,¹ and the three part study of 15 participating institutions in the Oak Ridge Associated Universities Program.²⁻⁴

Gallium-67 is cyclotron produced by proton bombardment of enriched zinc oxide. It decays to stable zinc Zn-67 by electron capture with a physical half-life of 78 hours. It produces four primary gamma emissions suitable for imaging on either the rectilinear scanner or the scintillation camera.

The routine injection dose for an adult is 3 millicuries. Because of the slow localization of the isotope, injection is necessary 48 to 72 hours prior to scanning. The areas of normal concentration include bones, liver and spleen. Excretion of the isotope is through the kidneys during the first 48 hours and into the colon thereafter.

Because of these characteristics, the demands of gallium scanning are more stringent than those of the usual brain, liver or bone scans. Patient selection, preparation, equipment set-up and operation are more exacting; and scan interpretation is more challenging. Because of the normal excretion of gallium into the colon, false-positive areas of uptake may occur and conversely, true pathology may be dismissed as normal bowel activity. Thus rigorous

bowel preparation similar to that for a barium enema must be done. Laxatives such as 15 mgm bisacodyl (Dulcolax) P.O. every day, beginning with injection, and 12 oz magnesium citrate P.O. the day before scanning and enemas the morning of the scan are usually adequate. If suspicious uptake is seen in spite of good preparation, repeat bowel cleansing and a new scan 24 hours later may be necessary. The time, expense, and importance of this procedure justifies the type of bowel preparation just outlined.

There is a wide variation in the deposition of normal activity on gallium scans; therefore, it is essential that the interpreter have experience with a number of normal scans to become familiar with the many variations of normal. Once these are clearly understood, gallium-67 uptake by pathological processes is frequently spectacular and often of definitive diagnostic value.

Gallium studies have been used to evaluate and search for many different types of neoplasm. At the present time the best results have been obtained in bronchogenic carcinoma, Hodgkin's disease, and other lymphomas excluding the lymphocytic type. The utility of gallium-67 with other malignancies has not been as well documented. It may eventually prove effective in melanoma and in metastatic testicular neoplasms.

To date clinical experience with Ga⁶⁷ for imaging primary tumors of the breast, head and neck, genitourinary system and gastrointestinal tract has been too disappointing to merit routine use.

Detection accuracy in Hodgkin's disease ranges from 70-75 per cent with the nodular sclerosing type showing the greatest overall efficiency (74 per cent). In malignant lymphoma the accuracy rate varies with histology, ranging from 70 per cent in histiocytic lymphoma to a dismal 35 per cent in poorly differentiated lymphocytic lymphoma. In both Hodgkin's and lymphoma the gallium scan may reveal positive sites that were not initially detected by any

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, the University of Mississippi Medical Center, Jackson, MS.

other method. This is one of the most valuable features of the procedure.

A national cooperative group evaluation of Gallium-67 in the detection of primary lung cancer demonstrated positive uptake in 84 per cent of the patients surveyed. Also a study from Italy reported positive uptake in 94 per cent of patients with peripheral lung lesions. Squamous cell carcinoma was somewhat more detectable than adenocarcinoma or small cell carcinoma. The detection rate for squamous cell was 81 per cent with 73 per cent for adenocarcinoma and 70 per cent for small cell carcinoma. A few false positives will be found here since inflammatory lesions such as sarcoid or granuloma also concentrate gallium.

At the present time these three types of malignancies comprise the bulk of gallium scanning for neoplastic disease. Investigation is continuing and other rewarding areas may be found. While gallium-67 citrate is still far from the ideal tumor seeking agent, it is the best available to date and has proven

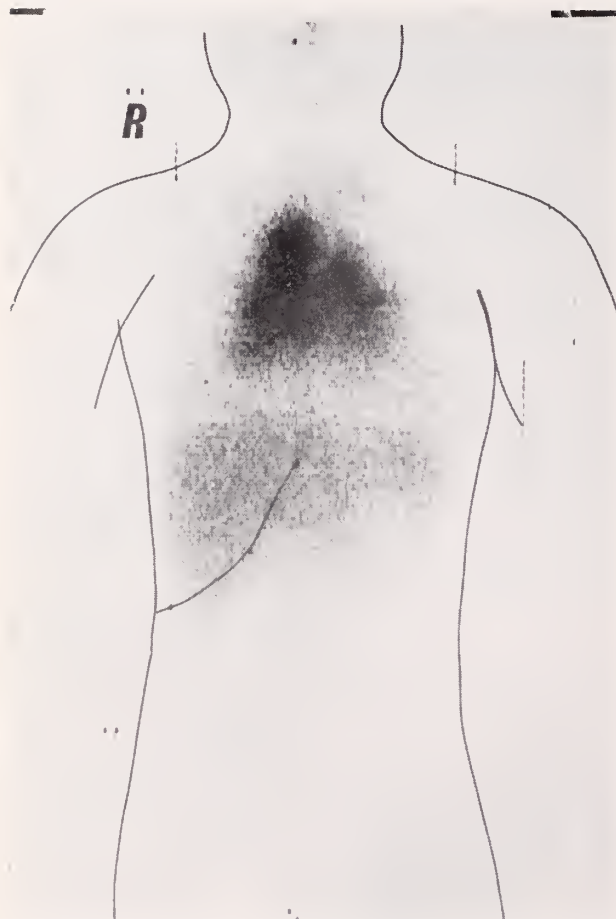


Figure 1. Anterior view. Fifteen-year-old female with nodular sclerosing Hodgkin's disease. Heavy abnormal activity is seen in the mediastinal area.



Figure 2. Posterior view. Same patient as Figure 1. The abnormal activity in the mediastinum is again visualized.

to be a valuable adjunct in the detection and staging of the tumors discussed above. ★★★

2500 North State Street (39216)

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4. Deland, F. H., Sauerbrunn, B. J. L., Boyd, C., Wilkinson, R. H., Jr., Friedman, B. I., Moinuddin, M., Preston, D. F. and Kniseley, R. M.: ^{67}Ga -Citrate Imaging in Untreated Primary Lung Cancer: Preliminary Report of Cooperative Group. *J. Nucl. Med.* 15:408-411, June 1974.
5. Pinsky, S. M. and Henkin, R. E.: Gallium-67 Tumor Scanning. *Sem. Nucl. Med.* 6:397-409, Oct. 1976.
6. Cellerino, A., Filippi, P. G., Chiantaretto, A. and Borasio, P.: Operative and Pathologic Survey of 50 Cases of Peripheral Lung Tumors Scanned With 67 Gallium. *Chest* 64:700-705, Dec. 1973.

PERSONALS

WILLIAM O. BARNETT of Jackson was guest speaker for the October meeting of the Ostomy Association of Jackson.

PHILIP J. BAYON announces his retirement from the practice of medicine in Natchez. Dr. Bayon practiced 30 years in Natchez.

E. E. BENOIST of Natchez announces that his practice of medicine and surgery at Suite 6, Medical Arts Building, will be discontinued as of Dec. 15.

HOWARD BOONE of Laurel was presented with a gift and plaque at a special reception in his honor for having practiced medicine in Laurel for the past 38 years. Friends hosted the event at Jones County Community Hospital. Dr. Boone retired last June.

WILLIAM BRADFORD of Waveland received an award from the city of Waveland and the Waveland Volunteer Fire Department for his services to the department.

P. TEMPLE CARNEY of Meridian announces the location of his office at North Hills Shopping Center for the family practice of medicine.

LOUIS A. FARBER of Jackson is a recent enrollee in the Medical Alumni Guardian Society of the University of Mississippi Foundation.

JAMES B. GRACE announces the opening of his office for diseases and surgery of the ears, nose and throat (otolaryngology) at the Medical Plaza, Vancleave Road in Ocean Springs.

HENDRIK K. KUIPER has associated with The Vicksburg Clinic for the practice of surgery.

ROBERT ASHFORD LITTLE of Gulfport has been elected for a three year term to the Board of Directors of the Tulane Medical School Alumni Association.

ANDREW K. MARTINOLICH, JR., of Bay St. Louis was re-elected chief of the medical-dental staff of Memorial Hospital at Gulfport. RONALD L. BROWN of Gulfport was re-elected vice chief of staff and W. K. STEWART of Pass Christian, secretary-treasurer.

MATTHEW PAGE of Greenville was honored with an Outstanding Citizens award at the Mixon Garrett Post 9732.

M. L. PATEL announces the opening of his office for the general practice of medicine and surgery at Tunica Clinic, Highway 61 North in Tunica.

JOHN L. PENDERGRASS of Hattiesburg has been named a Fellow of the American Academy of Ophthalmology and Otolaryngology.

H. R. POWER of Vaiden was honored with a reception at the public library by the townspeople on Oct. 16 for all his years of service and devotion to the people of the Vaiden area.

I. H. SALTZ announces the opening of his office for the practice of medicine next to the hospital in Osyka.

Five Hattiesburg physicians were honored by their colleagues at a Methodist Hospital staff meeting for their service to the people of Forrest County. Each received plaques commemorating their years of service. They are ROBERT E. SCHWARTZ, 50 years; EARL GREEN, 40 years; VAN C. TEMPLE, 40 years; H. GRADY COOK, 40 years; and HARRY C. FRIDGE, 40 years.

OMAR SIMMONS of Newton received his 50-year service pin and certificate at the East Mississippi Medical Society meeting.

PERRIN N. SMITH and CHARLES D. MILES of Columbus announce the opening of their office at The Columbus Women's Clinic, 425 Hospital Drive.

DEMPSEY STRANGE and STEVE PARVIN announce the opening of their Surgical Clinic at 106 Strange Road in Starkville.



The President Speaking

Restriction on Private Practice of Medicine

JAMES O. GILMORE, M.D.
Oxford, Mississippi

AMERICAN PHYSICIANS are facing an unprecedented number of attacks and restrictions on how they practice medicine.

The trend is unmistakably with government bureaucrats vying with each other to "go after the doctors." The Justice Department's antitrust division is racing neck and neck with attorneys in the Federal Trade Commission to regulate medical practice. On another level, many states are also enacting new rules and regulations around embattled physicians.

Laws are being passed both to spell out ways of disciplining physicians for alleged misconduct in the area of diagnosis and treatment and to tell them how to manage the business side of their practice.

First, and one of the vigorous efforts, is the drive by the FTC; next comes state actions on misconduct. Then comes the Justice Department, which enters in two areas: antitrust actions and activities by the Drug Enforcement Administration under the Controlled Substances Act. Meanwhile a more subtle effort is being made by HEW, in its conduct of reimbursement investigations under Medicaid and Medicare.

Another specter hovering over the medical profession is the question of relicensure. There has been continuing pressure both within and outside of the profession for continuing medical education. It has now reached the point where 19 states have passed legislation requiring physicians to upgrade their knowledge through CME in order to gain renewal of their licenses. Fourteen of these states have implemented this provision of their medical practice act.

What can be done to defend the physician against this ever widening wave of attacks and restrictions? Dr. James Sammons, executive director of AMA, says, "We're fighting the FTC on all fronts. We're fighting HEW proposals now before Congress. We're fighting to correct and eliminate some of the restraints that present or proposed legislation would impose."

At this time the future looks grim indeed, and how successful the AMA's, MSMA's, and others' defensive actions will be remains to be seen. Individual practitioners, unfortunately, lack the resources to counter these efforts on their own. By actively encouraging and supporting the efforts of their local, state, and national professional societies the chances of success will be increased. ★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XVIII, NUMBER 12
DECEMBER 1977

Duodenal Ulcer

The indications for surgical treatment of duodenal ulcer have long been standardized, i.e., hemorrhage, perforation, obstruction, and intractability. The most frequently done operation of vagotomy, antrectomy, and Billroth I gastroduodenostomy has a recurrence rate of less than one per cent, and a mortality rate of less than two per cent. Approximately 93 per cent of these patients have a satisfactory result, while 7 per cent are considered unsatisfactory due to weight loss and/or dumping syndrome.

In an attempt to reduce the sequelae of truncal vagotomy, newer operations are being tried. Selective vagotomy and highly selected vagotomy are an attempt to denervate only the stomach or antrum, without dividing the vagus fibers to the remainder of the G.I. tract. Proponents of these operations claim less dumping, diarrhea, and weight loss. There is, however, a higher incidence of recurrent ulceration.

Of particular interest is a new drug, Cimetidine, which is said to inhibit histamine receptors (H₂) of the gastric mucosa, thus reducing basal acid secretion. Patients taking this drug are pleased with the rapid relief of pain and minimal side effects.

In the last few years, there has been a marked decrease in the number of patients undergoing surgery for duodenal ulcer. Either the gastroenterologists are doing a better job or the newer drugs are more effective. Perhaps the time will come when surgery for duodenal ulcer is a thing of the past.

GEORGE H. MARTIN, M.D.
Associate Editor
Vicksburg, MS

Medico-Legal Brief

Mississippi Physician Files Medicare Fee Discrimination Suit Against HEW

The following is an excerpt from a lawsuit filed against the Secretary of Health, Education and Welfare by Dr. John O'Keefe, a Biloxi orthopedic surgeon. The suit charges that the Medicare program discriminates against Dr. O'Keefe and other Mississippi physicians by paying substantially lower fees than are paid to other physicians throughout the country.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

JOHN B. O'KEEFE, M.D. PLAINIFF
Versus
SECRETARY OF HEALTH, EDUCATION
AND WELFARE, AND THE UNITED
STATES OF AMERICA DEFENDANTS

COMPLAINT

COMES now JOHN B. O'KEEFE, Plaintiff, by and through his attorneys in the above styled and numbered cause, and files this his Complaint against the Defendants, the Secretary of Health, Education and Welfare, and the United States of America, and would respectfully show unto this Honorable Court as follows, to-wit:

I

That the Plaintiff, John B. O'Keefe, is an adult resident citizen of the City of Biloxi, Mississippi; that the Defendant, the Secretary of Health, Education and Welfare, was, at all times pertinent hereto,

MEDICO-LEGAL / Continued

and continues to be an officer, agent, servant and employee of the Defendant, the United States of America.

II

III

IV

That Part "B" of the Medicare Program, as enacted and amended aforesaid, and more particularly, 42 USC Section 1395 (u) as originally enacted and as amended, operates to create a contractual relationship between the United States Government through the Secretary of Health, Education and Welfare, and its agent health insurance carrier in the State of Mississippi, Travelers Insurance Company, for the administration of benefits including the determination of reasonable charges for physician's services performed by the Plaintiff, John B. O'Keefe; and that the aforesaid Secretary of Health, Education and Welfare has promulgated administrative rules and regulation for the administration of benefits under the aforesaid legislation.

V

That the Plaintiff, John B. O'Keefe, charges that 42 USC Section 1395 (u), as originally enacted and as amended, together with the Administrative Regulations promulgated by the Secretary of Health, Education and Welfare, pursuant to said legislation, contravenes the due process provisions of the Fifth Amendment to the United States Constitution, for one or more of the following reasons, to-wit:

- (a) That said legislation, together with the Administration Regulations promulgated thereunder, on its face, and in its application, operates to create classifications of physicians and physician reasonable charges for services, on a discriminatory basis, whereby the Plaintiff and other Mississippi physicians are paid benefits substantially lower than those benefits enjoyed by other physicians throughout the United States for the same services, and that Plaintiff is thereby denied the equal protection of the law embodied in the due process provisions of the Fifth Amendment of the United States Constitution, in that while the premium paid to the Carrier for administration of benefits is uniform throughout the United States, the benefits derived therefrom are substantially lower to your Plaintiff and Mississippi physicians than those benefits enjoyed elsewhere.

- (b) That there exists no compelling governmental interest which might justify the discriminatory administration of benefits aforesaid.
- (c) That in Medicare "B," as applied, the Plaintiff, other Mississippi physicians, and patients being treated pursuant to the Act are all deprived of property without due process of law, in that residents of the State of Mississippi are charged an insurance premium at a uniform national rate while receiving benefits far below these enjoyed in other States and localities, and that portions of said premium enrichen the benefits derived by others at the expense of the Plaintiff, other Mississippi physicians, and patients being treated pursuant to the provisions of the Act.
- (d) That said legislation, together with the administrative regulations promulgated thereunder, operates to discourage physicians from practicing in the less populous areas of the United States, and in the State of Mississippi, more particularly, and further operates to encourage physicians who might practice in less populous areas of the United States, and in the State of Mississippi in particular, to locate their practices in those larger urban areas where higher benefit payments are made, thereby defeating the purpose for which the Medicare Program was enacted, and sound public policy.

VI

That the Plaintiff, John B. O'Keefe, charges that as a direct proximate result of the aforementioned infringement of his constitutional rights, he has been caused to lose sums of money which he otherwise would have been entitled to receive, from the date of November 1, 1974 through November 30, 1975, said damages exceeding Ten Thousand Dollars (\$10,000) in amount, but limited to the sum of Ten Thousand Dollars (\$10,000) for the purpose of this cause of action.

VII

VIII

IX

WHEREFORE, Premises considered, the Plaintiff, John B. O'Keefe, prays for a judgment against the Defendants, the Secretary of Health, Education and Welfare, and the United States of America in the full sum of TEN THOUSAND DOLLARS (\$10,000) with interest, and all costs and disbursements of this action, and all general and equitable relief to which this Honorable Court may find Plaintiff entitled.

THE LITERATURE

Book Reviews

General Ophthalmology. 8th Edition. By Daniel Vaughn, M.D., and Taylor Asbury, M.D. 379 pages with illustrations. Los Altos, CA: Lange Medical Publications, 1977. \$12.00.

The eighth edition of *General Ophthalmology* by Vaughn and Asbury is an up to date review of the subject of ophthalmology primarily intended for medical students, residents, and general physicians not within the specialty of ophthalmology. References to anatomy and growth and development are offered and form an adequate review for the physician.

The chapter on examination is directed at the medical student and general practitioner and offers an outline for establishing an examination technique. Noted throughout the chapter are pertinent clinical factors which refer directly to signs and symptoms noted during the examination.

Principles of management of common ocular disorders are discussed adequately. Suggestions on necessary equipment, supplies, and medications needed for examination are given. Throughout this chapter, individual disorders are referred to as a helpful guide for the practitioner. Reference to trauma and ocular emergencies are stated with some of the more common pitfalls in the management of various ocular disorders being emphasized.

The book tends to direct the reader, in a systematic approach, to the different components of the ocular system. This includes discussion of disorders of the lids and lacrimal apparatus, and then progresses posteriorly throughout the component parts of the eye with discussion of more commonly noted disorders and associated signs and symptoms.

The chapter on the conjunctiva covers the numerous causes of conjunctivitis. Eleven general classes of etiologic agents are discussed with each yielding specific notations of pertinent signs and symptoms.

A review of anatomy and physiology of the cornea is presented with a classification of corneal ulcers with schematic diagrams and drawings. Degenerative corneal conditions are covered but much of the information given is more oriented to the ophthalmology resident.

In the section on the uveal tract, a brief review of the anatomy and physiology of the various com-

ponents of the uveal tract allows the reader to correlate symptoms he may incur with the actual tissue changes in the eye. Specific types of uveitis are discussed and suggestions for therapy are offered.

In discussing the retina, emphasis is placed on vascular occlusion and diabetic retinopathy. Retinal injury and retinal detachments are discussed.

A brief discussion of cataracts is offered with accompanying illustrations of various cataract types. Vitreous symptomatology is covered.

The chapter on neuro-ophthalmology gives a schematic illustration of the visual system from the optic nerve head posteriorly through the optic chiasm, tracts and into the visual cortex. Optic neuritis is discussed with an etiologic classification given. Specific references are made to ocular field defects and involvement of the areas creating such disorders. Various miscellaneous diseases which have some systems and correlation are noted. Reference is also made to some neurological findings associated with medications and toxic compounds. There is only a very brief reference to headaches. In view of the frequent complaints of headaches that the practitioner sees, a more definitive discussion could have been given.

The section on strabismus is an excellent review for the neophyte ophthalmic resident but should be of interest to the medical practitioner. Many diagnostic techniques noted would have meaning only to the ophthalmologist or those in ophthalmic training.

A classification of glaucoma was presented with reference to the physiology. Differentiation of open angle glaucoma and angle closure glaucoma was noted. Diagnostic technique and treatment methods in glaucoma are referred to.

A special section is devoted to the broad subject of tumors. Tumors of all layers of the eye, orbit, and lids, and relationship to systemic associated disorders are included.

Of interest to the practitioner is a brief section on trauma with suggestions for handling acute traumatic cases.

I feel that the chapter on ocular disorders associated with systemic diseases offers an excellent reference source for the practitioner and medical student. This chapter is written with specific reference to the common systemic disorders and to some of the rarer systematic conditions which have reflection within the eye. The chapter on optics and refraction would be of little interest to the general practitioner but does offer some food for thought for the ophthalmic resident.

LITERATURE / Continued

The chapter on preventive ophthalmology, in my opinion, is of little aid to the practitioner. References are made to special ophthalmic subjects of pediatric interest, such as congenital eye defects and normal ocular examinations in infants and children. Emphasis on referral of suspected conditions could be stressed more.

The chapter on blindness is a new addition to this text. A statement of the IRS definition of legal blindness is given. References are made to industrial blindness, the incidence, cause and prevention of blindness and rehabilitation of the blind.

In summary this text can be considered as a most adequate reference source for the general practitioner. The text also offers adequate reference material for the early ophthalmic resident and medical student. This book certainly points out the fact that the practice of ophthalmology is not limited entirely to the realm of the ophthalmic specialist.

ROBERT O. MAY, M.D.
Jackson, MS

Current Surgical Diagnosis and Treatment. 3rd Edition. By J. Englebert Dunphy, M.D., and Lawrence W. Way, M.D. 1139 pages, illustrated. Los Altos, CA: Lange Medical Publications, 1977. \$18.50.

Now in its third edition, this encyclopedia of general surgery presents in very concise form latest information on an exhaustive list of conditions. The entire text follows the same pattern and writing style which is almost unheard of considering the large number of "associate authors." This consistency greatly increases the usefulness of the book and, were it of proper size, I would be tempted to keep it in my pocket. Each is divided into the same categories: essential of diagnosis, general considerations, clinical findings, laboratory findings, differential diagnosis, complications, treatment and prognosis. Each subject is followed by a short but comprehensive bibliography. The chapters on surgical nutrition, burns, the thyroid, the spleen and legal medicine have been completely rewritten. New sections on tumor immunology and special diagnostic procedures have been added. The chapters on preoperative care and postoperative care are especially well written and comprehensive. While such wide coverage prevents detailed discussions, this is certainly the text that should be consulted first for an excellent overview of almost any surgical topic.

JACK B. CAMPBELL, M.D.
Jackson, MS

LETTERS

SIRS: Despite remarkable progress in the understanding of most infectious diseases, the causative agent of one relatively common disease remains unknown. Cat scratch disease (CSD), also known as cat-scratch fever or benign inoculation lymphoreticulosis, usually consists of a primary lesion at the site of a cat scratch, followed in a week or two by a subacute, self-limited illness, with malaise, fever, and a regional granulomatous lymphadenitis. Suppuration of the nodes may occur, but the pus is bacteriologically sterile. Rash, erythema nodosum, thrombocytopenia, conjunctivitis with enlargement of the homolateral preauricular nodes (Parinaud's oculoglandular syndrome) and encephalitis may occur as unusual complications. Although there is usually gradual spontaneous resolution of the lymphadenopathy, the disease may result in significant morbidity, large surgical and medical expenses, and confusion with more serious conditions such as lymphoma. Children are affected most frequently, and familial clustering of cases sometimes occurs, suggesting a common source of infection. Transmission by scratches, bites or licks of a cat has usually been postulated, but "typical" cases have also occurred without recognized cat contact.

The diagnosis of CSD currently depends upon the clinical picture, failure to demonstrate a bacterial etiology of the lymphadenitis, and the typical histopathological findings in biopsied lymph nodes. Chlamydial group complement-fixing antibodies are present in the sera of some cases (about 25 per cent) but rising titers are not seen, and it is not clear what relation, if any, chlamydiae might have to CSD. A skin test, using a crude non-standardized antigen prepared from the pus of typical cases, was utilized in the past but is not now recommended.

Numerous attempts have been made to isolate the etiologic agent, using traditional virological and bacteriological techniques, but the few reports of possible success have not been substantiated. Similarly, serologic tests against various other organisms besides chlamydiae have been negative. Future search for the cause of CSD should utilize newer techniques, such as primary cell culture or co-cultivation of acutely-involved lymph nodes, immune-electron microscopy, immunofluorescence, and immuno-enzyme staining procedures.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

1978 MSMA-Robins Award Is Announced

The seventeenth annual Mississippi State Medical Association-Robins Award for outstanding community service by a state physician has been announced



MSMA-Robins Award

to the component medical societies by the Board of Trustees. The 1978 award will be presented at the 110th Annual Session during closing ceremonies on May 4.

Dr. James O. Gilmore, president, and Dr. Robert Caldwell, chairman of the Board of Trustees, said that each component medical society has been invited to

submit a nomination for the honor. The award is cosponsored annually by the association and the A. H. Robins Company of Richmond, Va., a long-established manufacturer of ethical pharmaceuticals.

Drs. Gilmore and Caldwell said that nominees must be members of the state medical association and that the community service recognized by the local society's nomination must be apart from purely professional attainment, since suitable awards in this connection already exist.

Generally, the service by the physician-nominee should have benefitted the local or state communities in a civic, cultural, or general economic sense. It need not, however, have been a single achievement, since many outstanding citizens contribute to community betterment through a series of services in varying leadership roles.

Nominations should be made by letter, and there are no restrictions upon length or attached exhibits which assist in establishing the nominee's qualifications and record of achievement. Drs. Gilmore and Caldwell said that each letter of nomination must be signed by an officer of the component medical society. Nominations from previous years may be resubmitted.

Deadline for submission of nominations to the state medical association is Jan. 1, 1978. Each nom-

ination will be acknowledged, and the Board of Judges, consisting of the three MSMA vice presidents, will review the nominations.

The Robins series was instituted in 1962, and the award consists of a sculptured bronze plaque in bas-relief, engraved, and mounted on a mahogany panel.

The 16 Mississippi physicians who have received the high honor are Dr. Thomas G. Ross of Jackson, nominated by the Central Medical Society in 1962; Dr. Frank M. Davis of Corinth, by the Northeast Mississippi Medical Society in 1963; Dr. Howard A. Nelson of Greenwood, by the Delta Medical Society in 1964; and Dr. Maura J. Mitchell of Ellisville, by the South Mississippi Medical Society in 1965.

Dr. J. T. Davis of Corinth, by the Northeast Mississippi Medical Society in 1966; Dr. Frank M. Acree of Greenville, by Delta Medical in 1967; Dr. W. H. Anderson of Booneville by Northeast in 1968; Dr. Omar Simmons of Newton, by the East Mississippi Medical Society in 1969; Dr. W. J. Aycock of Calhoun City, by the Northeast Society in 1970; Dr. Walter H. Rose of Indianola, by Delta Medical in 1971; Dr. Reginald P. White of Meridian, by the East Mississippi Medical Society in 1972; Dr. W. A. Long, Jr., of Jackson, by the Central Medical Society in 1973; Dr. Virginia S. Tolbert of Ruleville, by Delta Medical Society in 1974; Dr. Thomas M. Davis of Jackson by Central Medical Society in 1975; Dr. Thomas G. Barnes of Greenville, by Delta Medical Society in 1976; and Dr. Hugh Banks Barnes of Hattiesburg, by South Mississippi Medical Society in 1977.

SBH Suit Awaits Action

AS JOURNAL MSMA went to press, a decision was still being anticipated on the association's motion to dismiss a suit filed by Governor Cliff Finch as an outgrowth of appointments made by the governor to the Mississippi State Board of Health which were not in accordance with state statutes.

The governor's suit seeks to void state statutes requiring MSMA and other professional associations to name nominees for appointment to the Mississippi State Board of Health. Hearings on the associa-

ORGANIZATION / Continued

tion's motion to dismiss Governor Finch's suit were conducted before Federal District Judge Walter Nixon in Biloxi during January.

Action on a companion "Quo Warranto" suit initiated by the State Attorney General and the association in Hinds County Circuit Court to remove Governor Finch's appointees on the basis of their not being appointed according to state statutes has been delayed pending a decision by the Federal District Court.

Pediatric Pulmonary Case Conference Held

The third annual LAMAT Pediatric Pulmonary Case Conference, sponsored by Lung Associations and Thoracic Societies of Louisiana, Arkansas, Mississippi, Alabama and Texas was held in Jackson recently at the Coliseum Ramada Inn.

Dr. Suzanne Miller, assistant professor of pediatrics and director of the Cystic Fibrosis Center, University of Mississippi Medical Center, served as conference chairman for Mississippi in addition to presenting cases.

Dr. Wilfred Q. Cole, UMC clinical associate professor of pediatrics, represented the Mississippi Thoracic Society and presented cases on "Wheezing in the Child Under Two."

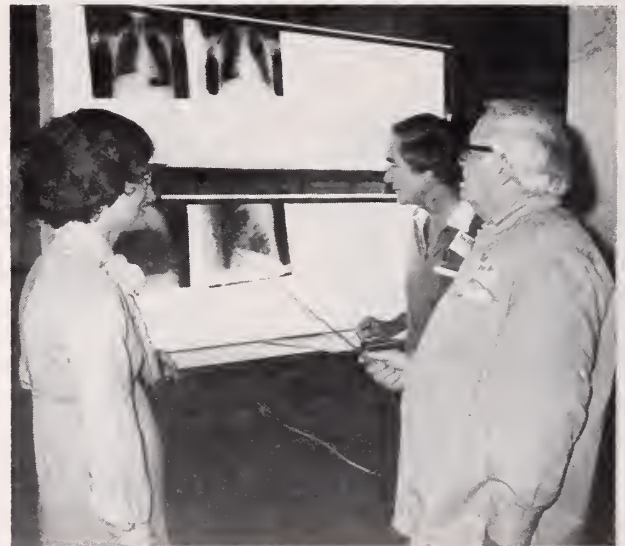
Other topics for case presentation included: asthma, cysts of the chest and mediastinum, tuberculosis, viral pneumonia in infants, and wheezing infants under three months.

Other participants were Dr. Gunyon Harrison, Baylor College of Medicine; Dr. Gerald Moore, Southwestern School of Medicine, Dallas; Dr. Ralph E. Tiller, University of Alabama Medical Center; Dr. Robert Harris, III, University of South Alabama College of Medicine, Mobile; Dr. Bettina Hilman, LSU Medical School; Dr. A. Joanne Gates, Tulane Medical School; Dr. Rosalind Abernathy, University of Arkansas for Medical Sciences; and Dr. Aram S. Hannissian, University of Tennessee.

Visiting guest consultants were Dr. Marie A. Capitanio, professor of radiology, Temple University School of Medicine, and director of radiology, St. Christopher's Hospital for Children, Philadelphia, Pa.; Dr. Herbert C. Mansmann, Jr., professor of pediatrics and associate professor of medicine, Thomas Jefferson University and Director of Division of Allergy and Clinical Immunology, Jefferson Medical College, Philadelphia, Pa.; and Dr. Ernest K. Cotton, professor of pediatrics and director of pediatric

intensive care unit, director of pulmonary division, University of Colorado School of Medicine.

The LAMAT Conference, providing postgraduate opportunities, is part of the medical and professional education program of workshops and seminars made possible by Christmas Seal contributions and Memorial Gift donations. Endorsed by the American Thoracic Society, the name LAMAT represents the five sponsoring lung and thoracic groups.



Mississippi pediatricians Dr. Suzanne Miller (left) and Dr. Wilfred Cole (back) both of Jackson, represented the Mississippi Thoracic Society at the LAMAT Pediatric Pulmonary Case Conference held in Jackson. Visiting guest consultant (front) Dr. Herbert Mansmann, Jr. of Jefferson Medical College, Philadelphia, Pa., participated in the two-day session designed for pediatricians and physicians who treat lung diseases and pulmonary problems in young children.

Medical Assistants and MSMA Will Sponsor Workshop

The Mississippi Chapter of the American Association of Medical Assistants and the Mississippi State Medical Association will sponsor two practice management workshops for medical assistants in Jackson Mar. 8-9 at the Coliseum Ramada Inn.

The workshops, which will be conducted by the AMA's Division of Medical Practice, will feature working sessions on office management, telephone, and good bookkeeping procedures. Special programs will also be presented on professional liability and medical ethics.

Registration and attendance at the workshops will be limited to 50 participants in each workshop and all attendees must be members of the Mississippi Chapter, AAMA. Registration materials will be mailed in early January.

Newborn Art Cards Are Available From UMC

The "best in show" entries from the 1976 and 1977 University of Mississippi Medical Center Newborn art competition are featured as cover art for Christmas and all occasion museum-style note cards now on sale from the Department of Special Services at the Medical Center.

The art contest, designed to spotlight health care needs of Mississippi babies and their mothers, is co-sponsored by the Newborn Center and the March of Dimes. Proceeds from all card sales go to the UMC Newborn Fund, which helps meet special needs of the UMC Newborn Center, not covered by usual budgeted funds.

The 1977 card is a four-color on ivory reproduction of Durant artist Frances Melton's watercolor, "Motherhood." Cards embossed with last year's winner, "Mother and Child" by Jackson artist Lewis West, are available in French blue with a Christmas greeting and in blue or white for use as all-occasion notes.

Both works are now a part of the UMC Newborn Center's permanent art collection.

Cards with or without the seasonal greeting are available in packets of 20 for \$6.00 or individually for \$.35 each. For mail orders, include \$.50 for postage and handling.

For more information write: Department of Special Services and Campus Relations, University of Mississippi Medical Center, 2500 North State Street, Jackson 39216.



Durant artist Frances Melton's "Motherhood" is featured as cover art on the 1977 University of Mississippi Medical Center Newborn Christmas and note cards.

UMC Names New Faculty Members

Dr. Roy Wilson is the new anesthesiology chairman for the School of Medicine, University of Mississippi Medical Center, and assistant dean for anesthesia affairs in the UMC School of Health Related Professions.



Dr. Wilson

The anesthesiology department also gained an associate professor in October while the neurology and family medicine departments added an assistant professor each, and the physiology department, one instructor.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced the appointments following approval of the Board of Trustees, Institutions of Higher Learning.

Dr. Wilson comes to the Medical Center from Baylor College of Medicine where he was professor of anesthesiology and vice chairman of the department.

He was on the faculty at the University of Texas Medical Branch in Galveston from 1963-1974, where he was chief of the anesthesiology division of the Shriners Burn Institute from 1966 to 1972.

A diplomate of the American Board of Anesthesiology and fellow of the American College of Anesthesiologists, Dr. Wilson's professional memberships include the Society of Sigma Xi, American Society of Anesthesiologists, International Anesthesia Research Society, American Burn Association, and the American Medical Association.

He has served as chairman of the anesthesiology section of the Southern Medical Association, vice-president and secretary of the Society of Military Anesthesiologists, and sectional vice-president of the Pan American Medical Association.

Chairman of the admissions committee of the National Board for Respiratory Therapy since 1974, Dr. Wilson is a senior examiner for the respiratory therapy board and a member of the standards committee on respiratory therapy of the Joint Commission on Accreditation of Hospitals.

Dr. Wilson is the author or coauthor of more than 120 scientific publications and educational tape recordings.

A B.A. graduate of Stephen F. Austin State College in Nacogdoches, TX, Dr. Wilson earned the M.D. at Baylor. He did his internship at Hermann Hospital in Houston and his residency at the United States Air Force Hospital, Lackland Air Force Base, TX.

Dr. Thomas Jones Herrin, Jr., new associate professor of anesthesiology at UMC, has been assistant professor of anesthesiology at Baylor College of Medicine since 1975.

A graduate of the University of Southern Mississippi, Dr. Herrin earned the M.D. degree at UMC in 1969. He did his internship at Mississippi Baptist Medical Center and his residency at UMC and the University of Texas Medical Branch in Galveston.

Dr. Jan E. Jordan, assistant professor of neurology, comes to UMC from San Antonio, TX, where he was chief of the electroencephalography laboratory at Bexar County Hospital and Audie Murphy Veterans Administration Hospital.

Dr. Jordan did his undergraduate work at the University of Cincinnati, Kendall College and Albion College, and earned the M.D. at Southwestern Medical School, University of Texas at Dallas. He did his internship at Milwaukee County Hospital, Milwaukee, WI, and his residency at Walter Reed Army Medical Center, Washington, DC. He did a fellowship at Duke University Medical Center and Durham Veterans Administration Hospital in Durham, NC.

UMC alumnus Dr. Harold David Brewer has joined the family medicine department faculty as assistant professor. He's been in private practice in Plant City, FL, since completing his internship at Tampa General Hospital in 1959.

Dr. Billy J. Barber, instructor in physiology and biophysics, has been a fellow at the Bowman Gray School of Medicine since July 1976. He holds the bachelor's, master's and Ph.D. from the University of Kentucky.

MSMA Reports CME Attendance of Members

MSMA has recently mailed a report on continuing medical education hours accumulated by individual members over the past year and reported to the association.

The MSMA CME reporting service for members began last year and some 70 members reported their CME hours.

The CME reporting service provides a mechanism for MSMA members to report their CME at-

tendance to the association's office where they are recorded and then annually reported back to the member.

MSMA members wishing to avail themselves of the service are asked to report the name or title of the CME activity, the sponsor of the CME activity, the dates of the CME activity and the number of CME hours obtained.

EKG Course Is Held at UMC

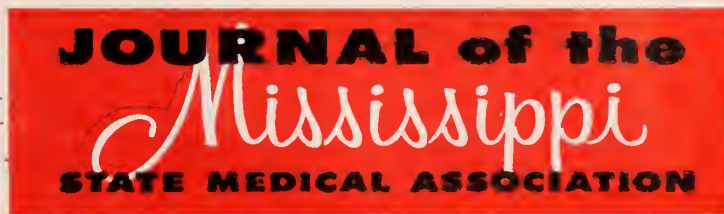


Dr. James Ray Foster of Biloxi (left), Dr. Henry M. Wadsworth, Jr., of Hernando (center) and Dr. Warren F. Ricchetti of Laurel were at the University of Mississippi Medical Center Oct. 10-14 for the EKG physician's intensive course.

Medical Center Sponsors Family Practice Review



The week-long family practice review sponsored by the University of Mississippi Medical Center family medicine department and continuing education division attracted more than 50 physicians including, from left, Dr. Grayden A. Tubbs of Fulton, Dr. Edward Hill of Hollandale, and Dr. Charles W. Campbell of Lexington. Conference headquarters for the Oct. 17-21 course was the Holiday Inn Medical Center.



VOLUME XVIII

January-December, 1977

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Jackson 39216

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SUBJECT INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "BR," Book Review; "MLB," Medico-Legal Briefs; "AP," Auxiliary Page; the asterisk (*) indicates an original ar-

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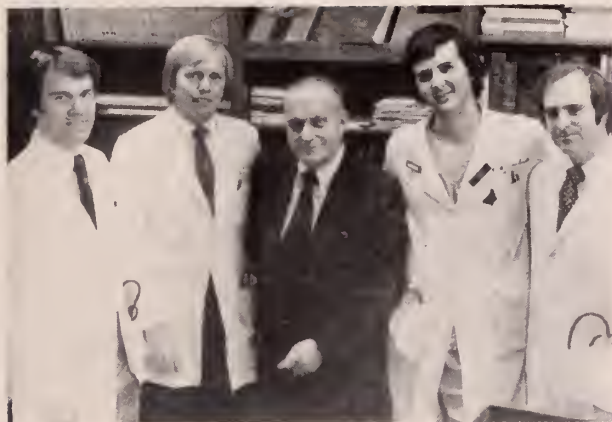
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UMC Hosts Visiting Professor



Dr. Theodore King, center, chairman of the ob-gyn department at Johns Hopkins, was visiting professor in the University of Mississippi Medical Center ob-gyn department in October and talked with UMC residents, from left, Dr. Mercer Lee of Forest, Dr. C. J. Sanders of Greenwood, Dr. Charles Bush of Jackson, and Dr. John Lucas of Demopolis, AL. During grand rounds, Dr. King spoke on "the Johns Hopkins experience—second trimester abortion." At a seminar the same day his topic was, "the fallope ring."



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IN CONCLUSION

Pointing to its long-standing opposition to compulsory retirement and other "artificial barriers to employment based on age," the AMA has reiterated support of H.R. 5383, a House and Senate passed measure which would expand existing federal prohibitions against discrimination in employment through the raising of mandatory retirement age from 65 to 70 for most employees. AMA's position is that middle-aged and older workers should be offered equal opportunities with others for gainful employment, based on their personal desires and capabilities.

"Greed" or the "desire to get something for nothing," is preceived by Ohio consumers to be a primary motivating factor for filing a malpractice suit according to research conducted by Ohio State University professors of consumer behavior. Study was conducted through a grant from Ohio State Medical Association Malpractice Research Fund. In telephoning 1500 Ohioans, researchers found the most important reason for deciding if you have a good doctor is whether the doctor talks with you about your problems. Some 67% respondents support arbitration for malpractice cases.

Some four million Americans suffer from peptic ulcer disease. Medical care for these patients, and the earnings they lose because of illness and death, will cost U.S. an estimated \$3.2 billion in 1977 alone, up from \$2.6 billion in 1975. A definitive estimate of the cost of ulcer disease in the U.S. was contained in a study prepared by SRI International of Menlo Park, Ca. Other findings included: hospital care will account for \$1 billion and physicians and related services will total \$283 million.

A survey of American physicians shows that 94% of those polled believe there is too much violence on television. And half of those surveyed suspect that the effects of TV violence may be showing up in their office and hospital, according to the poll conducted by the AMA. Examples of behavioral and medical problems doctors cited that may stem from exposure to TV violence include heightened aggression in children, injuries resulting from emulating television incidents, epileptic seizures, and nightmares.

The average alcoholic has been in difficulty with alcohol for 10 years before he or she seeks help because of severe illness. If alcoholism is identified early, much destruction can be prevented. The Malvern Institute of Malvern, Pa., published in JAMA certain early symptoms to watch for: heartburn, morning cough, increased pulse rate, high blood pressure, tremors in middle age, bruises that might have been caused by stumbling, anxiety, tension and stress, insomnia, high blood sugar and enlarged liver.

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psycho-

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tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

ship has not been established clinically.

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